AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS THURSDAY 18TH JULY 2019 VENUE: THE MIDDLESBROUGH FOOTBALL CLUB, RIVERSIDE STADIUM, MIDDLESBROUGH, TS3 6RS AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the last meeting held on **25th June 2019.**		**Attached**
Item 2	Matters Arising.		**-**
Item 3	Public Board Action Log.		**Attached**
Item 4	Declarations of Interest.		**-**
Item 5	Chairman's Report.	**Chairman**	**Verbal**
Item 6	Chief Executive's Report.	**EM**	**Attached**
Item 7	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.50 am)

Item 8	To receive a briefing on key issues in the Tees Locality.	**Dominic Gardner to attend**	**Presentation**
Item 9	To receive and note the report of the Guardian of Safe Working.	**Dr. Whaley to attend**	**Attached**
Item 10	To consider the six monthly "Hard Truths" Nurse Staffing Report.	**EM**	**Attached**
Item 11	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 12	To approve the Workforce Race Equality Standard and Workforce Disability Standard associated action plans.	**DL**	**Attached**
	(Note: the outcome of the discussions of the Resources Committee on the above matters will be reported at the meeting)	**MH**	**Verbal**

Item 13	To receive and note a report on the implementation of an early warning system for community teams.	**EM**	**Attached**
Item 14	To approve the Triangle of Care Stage 2 submission.	**EM**	**Attached**

Performance (11.20 am)

Item 15	To consider the summary Finance Report as at 30th June 2019 including the Quarter 1, 2019/20 submission to NHS Improvement.	**PM**	**Attached**

(Note: the Performance Dashboard Report will be circulated to Board Members under separate cover due to the meeting being held early in the month)

Governance (11.25 am)

Item 16	To receive and note a report on the Trust's position under the Single Oversight Framework.	**PB/SP**	**To follow**

Items for Information (11.30 am)

Item 17	To received and note a report on the use of the Trust's seal.	**EM**	**Attached**

Item 18 To note that the next meeting of the Board of Directors will be held on **Tuesday 24th September 2019** in the Boardroom, West Park Hospital, Darlington at 9.30 am.

Confidential Motion (11.35 am)

Item 19 **The Chairman to move:**

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

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

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

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

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

Miriam Harte
Chairman
12th July 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 25TH JUNE 2019 IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON COMMENCING AT 9.30 AM

Present:
Ms. M. Harte, 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 and Deputy Chief Executive
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Mr. M. Eltringham, Public Governor for Stockton-on-Tees
Mr. A. Williams, Public Governor for Redcar and Cleveland
Mr. M. Williams, Public Governor for Durham
Mr. P. Bellas, Trust Secretary
Mrs. S. Paxton, Head of Communications
Mrs. K. Ord, Deputy Trust Secretary
Ms. B. Thomas and Ms. L. Simmonds, Community Nurses (shadowing Mrs. Moody as part of the Florence Nightingale Learning Disability Nurses Leadership Programme)
Mr. N. Ayre, North Yorkshire Healthwatch
Mr. G. Morris, Member of the Public

19/153 MINUTES

Agreed *– that the minutes of the last meeting held on 21st May 2019 be approved as a correct record and signed by the Chairman.*

19/154 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

Arising from the report:
(1) In response to a question, clarity was provided that the action under minute 19/100 (30/4/19) was rated as “amber” as, although the position on the full CQC action plan had been presented to the Board meeting held on 21st May 2019 (minute 19/131 refers), the report under agenda item 10 represented the first monthly exception report on the “must do” actions.
(2) The final version of the Annual Report, including the Quality Report, and Annual Accounts 2018/19 had now been submitted to Parliament and NHS Improvement (minute 19/134 – 21/5/19 refers).

19/155 DECLARATIONS OF INTEREST

There were no declarations of interest.

19/156 CHAIRMAN'S REPORT

The Chairman reported on the following matters since the last meeting:

(1) Her attendance at the meeting of the Council of Governors held on 22nd May 2019 which had been interesting and helpful.

(2) Her attendance at the Research and Development Conference on 24th May 2019 which followed the Board's consideration of the Research and Development Annual Report a few days earlier (minute 19/128 – 21/5/19 refers).

Ms. Harte:

(a) Highlighted that the Conference had been very illuminating in terms of the research being undertaken and the people involved in it.

(b) Drew attention to the benefits of encouraging research not only for patients but also to support the recruitment of high calibre staff.

(3) Her enjoyable visit to Holme House to present a Living the Values Award.

(4) The continuing work and discussions on the development of the ICS.

The Board noted that:

(a) On 19th June 2019 NHS England had published "Designing integrated care systems (ICSs) in England" which provided an overview of the arrangements needed to build strong health and care systems across the country.

(b) It was clear that the development of ICSs was not being taken forward based on a "one size fits all" approach but through an iterative process.

(c) A draft memorandum of understanding had been prepared for the ICS which would be presented to the Board in due course.

(5) The ongoing recruitment of new Non-Executive Directors.

19/157 CHIEF EXECUTIVE'S REPORT

The Board received and noted the Chief Executive's Report.

Mr. Martin highlighted the following matters:

(1) The tremendous work undertaken by the Trust's staff and services in response to the issues at Whorlton Hall (minute 19/C/147 – 21/5/19 refers) and the continuing support being provided by TEWV and Northumberland, Tyne and Wear NHS Foundation Trust.

Board Members:

(a) Echoed Mr. Martin's sentiments.

(b) Noted that it would take some further time to resolve the issues arising from the incidents at the Hospital.

Mrs. Richardson reported on her recent visit to learning disability services at Bankfields Court which had provided an opportunity for discussions with staff, about the issues at Whorlton Hall, and with patients.

The high levels of compassion demonstrated by staff had made her proud of the Trust's services.

(2) The ballot on the new Junior Doctor Contract, to replace the version imposed in 2016, which was due to close on 26th June 2019.

(3) The themes and key actions contained in the Interim People Plan for the NHS, as summarised in the report, which had recently been published by NHS England/Improvement.

It was noted that:

(a) An interim plan had been published as certain elements (e.g. funding for training and education) remained subject to the Comprehensive Spending Review.
(b) Many of the actions included in the Interim Plan, including the focus on expanding training places and recruitment and retention, were already being taken forward by the Trust.
(c) The Resources Committee would be invited to hold detailed discussions on the implications of the Interim Plan.

In response to questions, Mr. Martin reassured the Board that:

(a) The Interim Plan was designed to reflect the workforce needs of the future and took into account whole person care; flexibility and adaptability of training across whole careers; and the development of new roles.

He considered that an area where further work was required, nationally, was in regard to the workforce requirements for the whole care sector and not only the NHS.

(b) Leadership development was a key element of the Interim Plan.

In addition Mr. Martin reported that the Trust's bid to progress whole pathway commissioning for children and young people's services had been successful.

In response to questions it was noted that the approach:

(1) Would cover the footprint of the Trust.
(2) Had the full support of the CCGs and local authorities.
(3) Was similar in methodology to an ICS albeit for a limited range of services.

19/158 GOVERNOR ISSUES

A summary of changes to the membership of the Council of Governors, following the recent annual elections, was tabled at the meeting.

In response to a question it was noted that further elections, to seek to fill the remaining vacancies, were planned to be held in November 2019.

Mr. Bellas undertook to circulate an electronic version of the document to Board Members.

Action: Mr. Bellas

19/159 REPORT OF THE QUALITY ASSURANCE COMMITTEE

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

(1) The confirmed minutes of its meeting held on 2nd May 2019 (Annex 1 to the report).

(2) The key issues considered by the Committee at its meeting held on 6th June 2019.

Dr. Griffiths, the Chairman of the Committee:

(1) Advised that there were no matters for escalation to the Board arising from the latter meeting.

(2) Highlighted the work underway to understand the increased rates of seclusion; however, it had been recognised, previously, that there were risks of double counting from AMH services and PICUs on this matter.

Mrs. Moody advised that:

(a) Work had been undertaken to address the risks of double counting in the seclusion module on the PARIS System.

(b) An audit of seclusion had been undertaken for the Mental Health Legislation Committee and a report on its findings was awaited.

Board Members raised the following matters:

(1) The statement in section 1.3 of the draft Positive and Safe Annual Report (published in error with the agenda), that there had been "significant reductions in the uses of restrictive interventions" as this did not seem to be supported by the data provided in the report.

Mrs. Moody:

(a) Provided clarity that restrictive interventions covered all types of restraint together with seclusion and rapid tranquilisation.

(b) Considered that, whilst there was variation, the data showed significant reductions in the use of certain restrictive interventions.

(c) Advised that the further discussions on the use of restrictive interventions at a future Board Seminar, as agreed at the last meeting, would support deeper understanding of the report's conclusions.

(2) The reference in the report to the potentially inappropriate movement of a patient at Westerdale North and whether work was being undertaken to ensure this type of incident, being the second instance recently reported, was not symptomatic.

The Board noted that the incident had been previously reported via the Reportable Issues Log (minute 19/C/114 – 30/4/19 refers) and was, at present, under investigation.

Mrs. Moody reported that, from her recent meetings with ward managers and modern matrons from both within the Tees Locality and subsequently across the Trust, it was considered that the inappropriate movement of patients was not widespread; that there were no concerns about the issue; and that the context and circumstances in which incidents happened needed to be understood.

(3) Whether it was planned to commence the flu vaccination campaign earlier in the year, than usual, in response to the surge in cases being experienced in Australia.

Mr. Levy advised that:
(a) The flu vaccination plan for 2019/20 was due to be considered by the EMT on 26th June 2019.
(b) A communication to staff to raise awareness of the flu vaccination campaign, which was planned to be circulated during the next couple of weeks, would draw attention to the problems being experienced in Australia.

Mr. Martin added that a film on the impact of flu on staff and patients at Rowan Ward, where an outbreak had been experienced last year, would be used in the forthcoming campaign.

19/160 NURSE STAFFING REPORT

The Board received and noted the exception report on nurse staffing for May 2019 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 raised the following matters:
(1) The reasons for the high number of staff on alternative duties on Westerdale South.

Mrs. Moody:
(a) Explained that the two most common reasons for staff being placed on alternative duties were in response to their physical health problems or as an alternative to suspension under the disciplinary policy.
(b) Undertook to look into the issue and provide details to Board Members.

Action: Mrs. Moody

(2) With reference to the Westwood Centre, how a reduction in bed occupancy was managed in the context of the staff roster.

It was noted that:
(a) The staffing establishments, underpinning the rosters, were set.
(b) Reductions in staffing requirements, in response to bed occupancy levels, would be reflected as low staffing fill rates.

(c) It was recognised that the national metric based on the ratio of the planned versus the actual fill rate provided crude assurance; however, the key issue was to understand the reasons for the position on a ward.

(3) The need for further assurance on workforce deployment in view of the reference in the report that there was little spare capacity in nursing establishments as they were planned for maximum efficiency.

Mrs. Moody advised that:

(a) The establishment reviews were progressing and the outcome of this work was due to be reported to the Board by the end of the financial year.
(b) Establishments were planned for maximum efficiency; however, levels of bed occupancy and patient acuity provided a rationale for additional staffing.
(c) Vacancy rates, particularly for registered nurses in North Yorkshire and York, together with there being limited slack in place led to demand for agency staff.

(4) The correlation between the Lodge being discounted from the staffing fill rate, due to the transition to a third party organisation, and its position within the top five wards under the severity rating scale.

It was noted that:

(a) As part of the transition, staff from the third party organisation had worked on the ward but were not included on the roster.
(b) Although there were sufficient staff overall, the circumstances had led to the ward showing a low fill rate.
(c) The ward, in view of the false negative position, should have been removed from the severity rating scale as well as being discounted in terms of fill rate.
(d) The transition had been well handled.

The Board discussed whether reporting on the fill rates of wards should be discounted in exceptional circumstances.

It was suggested that, where wards had low fill rates due to exceptional circumstances, they should continue to feature in reports, as their position could impact on service delivery, but a note of explanation should also be included.

However, Mrs. Pickering reminded the Board of its decision to remove these cases as there were risks that issues impacting on other wards would be obscured if they were, otherwise, not ranked high enough to feature in the report.

(5) Whether the severity rating scale should be reviewed.

Overall, Board Members recognised that the severity rating scale was beneficial, as it was both quantifiable and crystallised issues in one place, but considered that it might be an opportune time to refine the approach.

Mrs. Moody advised that further discussions on this matter could be held as part of the consideration of the six monthly nurse staffing report which was due to be presented to the Board Meeting on 18th July 2019.

(6) The need for the number of incidents citing staffing levels for a month to be placed in context.

Mrs. Moody:

(a) Undertook to provide contextual information in future reports:

Action: Mrs. Moody

(b) Advised that escalation reporting for community services had been introduced and the data could be included in future nurse staffing reports.

(c) Explained that the Trust encouraged reporting; however, at present, the position was believed to be lower than in reality.

(d) Advised that the need for, and benefits from, escalation reporting had been emphasised at her recent meeting with ward managers.

In response to a question, it was noted that all outliers, in terms of reporting, were reviewed.

19/161 CQC ACTION PLAN

Further to minute 19/100 (30/4/19) the Board received and noted an exception report on the delivery of the 'must do' actions contained in the CQC action plan.

In response to questions, Mrs. Moody advised that:

(1) In regard to action ref. 50, mixed sex wards were allowed but certain standards (e.g. designated single sex areas; males not passing female bedrooms, etc.) needed to be put in place and maintained and these were incorporated in Trust policy.

The Board noted that breaches of the standards tended to occur due to wards being overly flexible and such instances had been observed by the CQC and during mock inspections.

(2) In recognition that some of the "should do" actions, set out in the report, were regularly highlighted in feedback from the CQC MHA visits, an event, jointly sponsored by her and Mrs. Hill, was being arranged for 8th July 2019 to explore why compliance was not being consistently achieved; to clarify issues of responsibility and accountability; and to develop standard work for modern matrons.

It was noted that the modern matrons had been very supportive of, and engaged in, this approach and the event also provided an opportunity for them to learn from each other.

Mrs. Moody also informed the Board that, following the receipt of a provider information request from the CQC, earlier in the day, it was expected that the next inspection of the Trust would be held during the next six months.

19/162 AGENCY REDUCTION ACTION PLAN

Further to minute 19/C/82 (26/3/19), the Board received and noted a progress report on the planned actions and outcomes to reduce the Trust's current agency spend.

Board Members welcomed the report.

The following matters were raised in the discussions:

(1) The importance of ward managers being able to learn how to better respond to the staffing challenges they faced.

It was noted that the agency visibility control board could be drilled down to ward level to provide feedback and was a real enabler of learning by ward managers.

(2) The importance of the effective management of the rosters in the context of the information and assurance provided to the Board.

Mrs. Moody advised that significant work had been undertaken on the management of the rosters but there was more to be done. As part of this, a paper was due to be considered by the EMT on 26th June 2019 which included recommendations to improve the quality of the use of the roster.

(3) Reporting arrangements to enable the Board to track progress against the action plan and gain assurance on its effectiveness.

Mr. Martin advised that:

(a) As suggested in the report, although there should be a significant reduction in agency usage during 2019/20, the Trust would not return to being within its cap until 2020/21.
(b) The challenges in regard to medical recruitment had been previously discussed by the Board. There were certain areas where recruiting into posts would remain difficult but overall the position should improve.
(c) A reduction in agency usage should be evident by September 2019 through the nurse staffing and finance reports and it would be beneficial for the Board to undertake a review of the impact of the actions at that time.

It was also noted that:

(a) In addition to recruitment, work was being undertaken to improve retention and the Trust was now better sighted on this issue.
(b) There were reasonable grounds to believe that the recruitment of new HCA starters onto band 3 (resulting in a 20% pay uplift) would have a significant impact and this should be noticeable in the near future
(c) In terms of assurance, updates on the delivery of the Right Staffing Programme were provided in the quarterly Strategic Direction Performance Reports.
(d) Oversight of the delivery of the action plan would also be undertaken by the Resources Committee.

(4) The reasons for the time taken to put in place a systematic plan to reduce agency usage as the issue had been apparent for some time.

Mr. Martin responded that:

(a) The Trust's agency usage and spend compared well to others but the position was higher than was wanted.
(b) Work to address agency usage, for example by aiding staff retention, through increasing notice periods, and reducing demand, through the introduction of zonal care, had commenced some time ago but had taken time to develop.
(c) The continuing increase in the acuity of patients in inpatient services had been surprising.
(d) In hindsight, further action could have been taken sooner.

Mr. McGahon also highlighted that the Trust had commenced use of the NHSI diagnostic tool in February 2019 but, as this was a 10 week process, its impact was only now coming to fruition.

(5) The importance of undertaking recruitment continuously in order the reduce agency expenditure as every post filled, substantively, provided a saving against the cap and built resilience.

Mr. Martin explained that ongoing recruitment was being undertaken together with measures to support retention; however, the Trust was operating in a very difficult market.

(6) The relationship between medical agency expenditure and the agency cap.

It was noted that:

(a) Medical agency expenditure was included in the cap, equating to approximately 50% of its total.
(b) The cap was based on a percentage reduction of actual expenditure and so did not recognise the challenges arising from the national shortage of psychiatrists.
(c) Consideration was needed on how medical agency expenditure was reported to the Board; either within the report or separately.

Dr. Khouja considered that medical agency expenditure should be both included in the report, in view of its impact on the cap, but also through other reporting in order to draw out the subtleties of medical recruitment and retention.

(7) The need for further explanation of the comment in the report on the current trend in resignations amongst medical staff and the risks that it might increase.

Dr. Khouja observed that:

(a) The turnover rate for medical staff was subject to variation but there had not been a recent increase in resignations.
(b) Where medical staff resigned there was likely to be an increase in pressure leading to demand for agency staff.

(8) The importance of reducing agency usage in terms of quality and safety.

Mrs. Hill assured the Board that communications to staff on agency usage focussed on quality and safety and not on the financial impact.

(9) The issue of agency staff not turning up for shifts as mentioned in the Nurse Staffing Report.

The Board noted that this matter continued to be kept under review.

19/163 FINANCE REPORT AS AT 31ST MAY 2019

The Board received and noted the Finance Report as at 31st May 2019.

In response to questions, Mr. McGahon advised that:

(1) Financial performance was behind plan, at month 2, due to cost pressures, for example, agency costs at the Westwood Centre and Acomb Garth. Recovery plans, to return to plan, had been agreed with each Locality and their delivery was being monitored.

(2) The delivery of CRES was ahead of plan principally due to non-recurrent schemes. These tended to be capital schemes which would provide recurrent savings, but not to the same level, in the future. Overall the Trust was planning to meet its CRES requirements through recurrent schemes going forward.

(3) In regard to the Use of Resources rating and indicators.
- (a) A weighting was applied to the indicators to derive the overall rating.
- (b) If the Trust's rating reduced to 4 it would trigger monthly reporting to NHS Improvement.
- (c) Through discussions at the Quarterly Review Meetings, it was clear that NHSI was satisfied with the Trust's rating taking into account the robustness of its financial position.
- (d) The rating of 4 for capital service cover reflected the way the indicator was applied, for example, in May 2019, the position had been distorted by the repayment of a loan. It was, therefore, important for the Board to consider the forecast position.

The Non-Executive Directors considered that, taking into account the explanations provided, the Trust was placed securely within the 3 rating and an early warning system was in place to highlight any deterioration in that position.

19/164 PERFORMANCE DASHBOARD AS AT 31ST MAY 2019

The Board received and noted the Performance Dashboard Report as at 31st May 2019.

Board Members:

(1) Further to the discussions on the appropriateness of the trend lines on the graphs (minute 19/137 – 21/5/19 refers), welcomed the intention to move to using statistical process charts for reporting.

(2) Sought clarity on the views of the EMT on the position on KPI 14 (Percentage of patients re-admitted to Assessment & Treatment wards within 30 days) in view of concerns that the position was at its highest level and was continuing to increase.

On this matter it was noted that:

(a) The position on the metric, which was based on the proportion of all readmissions, was reviewed at the monthly EMT performance report outs.
(b) The Localities, having reviewed each case, had provided assurance that all the readmissions were appropriate in terms of clinical need. For example, the review undertaken in the Tees Locality had highlighted that one of the main reasons for readmissions related to substance misuse.
(c) It was also apparent that, as there were relatively few cases, a small increase in readmissions could distort the overall position.
(d) In the circumstances, actions which could be taken by the Trust, apart from reviewing the construction of the metric, were limited.
(e) The EMT would continue to keep the matter under review.

Dr. Griffiths considered that:

(a) Whilst the admissions might be appropriate in terms of clinical need, the position could reflect underlying issues, for example, the premature discharge of patients by inpatient services.
(b) It would be beneficial for Board Members to receive a refresh of the cases broken down by diagnosis as provided previously to the Quality Assurance Committee.

Action: Mrs. Hill

(3) Whether the number of times North Durham was mentioned in the context of variation in the delivery of the Single Oversight Framework targets at CCG level was surprising and the reasons understood.

Mrs. Pickering explained that:

(a) Performance against the IAPT recovery indicator by CCG area in County Durham tended to vary and, although missed, that for the North Durham CCG area was not significantly under target.
(b) The metric on “Inappropriate Out of Area Occupied Bed Days” was based on a percentage reduction and achieving target was more challenging in North Durham as it had started from a low base. This matter had been discussed with the CCGs but they considered that the metric should not be changed at this time.

19/165 BOARD PERFORMANCE EVALUATION SCHEME

The Board received and noted a report on the findings of the Board Performance Evaluation Scheme for 2018/19.

The focus of the discussions was on the level of direct interaction between the Board and service users and carers; the lowest scoring issue identified from the review of Board effectiveness.

Mr. Martin advised that the issue had been discussed at the regional meetings of the Chief Executives and, whilst service users and carers attended Board meetings at some trusts, this was not universal and there were differing views on its value.

He considered that, at present, there were many opportunities for Board Members to engage with service users and carers and, as a first step, it would be worthwhile to map those interactions to provide visibility and to inform future discussions.

This approach was welcomed.

Action: Mr. Martin

Board Members also highlighted:

(1) The potential split between the Executive and Non-Executive Directors in observing and engaging with service users and carers as, for example, no or only a limited number of Non-Executive Directors were often invited to attend events.

Mrs. Hill highlighted her recent attendance at an event by Converge and questioned whether any other Board Members had received an invitation.

(2) The importance of the event, being taken forward to mark the passing of people who had died in services, in bringing people together and to recognise the work undertaken by the Trust.

(3) The benefits, on this matter, from Non-Executive Director participation in MHA panels.

(4) The means by which Board Members already heard the patient and carer voice (e.g. MHA panels, SI reviews, Director visits) and the challenges of capturing this to ensure Board understanding and so that views could be triangulated.

(5) The potential benefits of providing patient stories to Board meetings but also the challenges from the environment for those presenting them.

The Board noted that, at some trusts, patient stories were delivered by proxy and this approach diminished their impact.

(6) The potential benefits of including meetings with service user and carer groups in the programme of Director Visits.

Whilst it was considered that this approach could be worthwhile it was recognised that the groups might have their own priorities.

(7) The development of the stakeholder network by Humber Teaching NHS Foundation Trust.

(8) The recent Kaizen event which had focussed on service user involvement in governance processes.

It was noted that one of the outcomes of the event was to seek to expand the coverage of shadow Quality Assurance Groups to all Localities and Specialties to provide a more consistent approach to involvement in the governance structure.

(9) The risks of tokenism if there was an imbalance between attendance at Trust events and those arranged by others.

In conclusion the Chairman considered that there was a range of opportunities, as evidenced in reports, for the Board to engage with service users and carers but, at

times, the means by which views were captured; responded to (e.g. the outcome of SI panels); and impacted on the work of the Trust was not always clear.

In addition a summary of the scores from the performance evaluations of the Committees, and the key actions being taken forward by them in response to the results, was provided in Annex 1 to the report.

Clarity was sought on the review of the Board's committees which would include the potential establishment of a workforce committee, as suggested by the Resources Committee, to enable sufficient consideration to both workforce/HR issues and financial matters in the governance structure.

The Board noted that the review was planned to be undertaken by the Chairman, in consultation with the Non-Executive Directors, over the summer months.

It was considered that the review needed to be properly bounded as the terms of reference of the Resources Committee covered all resources not only workforce and financial matters.

19/166 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.

19/167 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 **18th July 2019** in the Riverside Stadium, Middlesbrough.

19/168 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 12.30 pm.

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**18th July 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
19/07/2018	18/218	A further review of the Board's committee arrangements to be undertaken	PB	Sept-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	Jul-19	See Agenda Item 13
26/02/2019	19/38	The collection of data on staff sent home due to flu to be looked into	DL	Jul-19	Completed
26/03/2019	19/65	A further report on waiting times to be presented to the Board	RH	Sep-19	
26/03/2019	19/66	The response from the DWP to the letter highlighting concerns about the impact of benefit cuts on some vulnerable service users to be provided to Governors via the Governor Briefing	AK	-	Timing dependent on the receipt of the response from the DWP
26/03/2019	19/67	The issue of reporting two sets of data on the gender pay gap, due to the impact of salary sacrifice, to be raised at a national level	DL	Sep-19	
30/04/2019	19/103	The shortage of SOADs and its impact on operational services to be included in the corporate risk register	RH	Jul-19	
21/05/2019	19/129	Clarity to be provided on the recording of the use of tear resistant clothing	EM	Jul-19	

	Minute No.	Action	Owner(s)	Timescale	Status
21/05/2019	19/129	A Board Seminar discussion to be arranged on restrictive interventions	CM	To be included in the review to be undertaken in August 2019	
21/05/2019	19/139	The WRES and WDES associated action plans to be presented to the Board for endorsement	DL	18/07/2019	See Agenda Item 12
21/05/2019	19/139	The Equality Data documents to be considered in more detail by the Resources Committee *(Evidence from the Kings Fund on the impact of discrimination against staff on patient experience to be provided to the Committee)*	DL	Jul-19	The documents are due to be considered by the Resources Committee on 15/7/19
25/06/2019	19/158	The document setting out changes to the Council of Governors following the recent annual elections to be circulated electronically to Board Members	PB	-	Completed
25/06/2019	19/160	The reasons for the high number of staff on alternative duties on Westerdale South to be reviewed and details to be provided to Board Members	EM	Jul-19	
25/06/2019	19/160	To note that contextual information on the number of incidents citing staffing levels is to be provided in future Nurse Staffing reports	EM	Jul-19	See Agenda Item 10
25/06/2019	19/164	Board Members to be provided with a refresh of the cases of readmissions within 30 days (KPI 14) broken down by diagnosis as provided previously to the Quality Assurance Committee	RH	Sep-19	
25/06/2019	19/165	The opportunities for Board Members to engage with service users and carers to be mapped	CM	Oct-19	

ITEM NO 6

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday 18 July 2019**
TITLE:	**Chief Executive's Report**
REPORT OF:	**Colin Martin, Chief Executive**
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:

A briefing to the Board of important topical issues that are of concern to the Chief Executive.

Recommendations:

To receive and note the contents of this report.

MEETING OF:	**Board of Directors**
DATE:	**Thursday 18 July 2019**
TITLE:	**Chief Executive's Report**

1. Capital Plan 2019/20

All Integrated Care Systems (ICSs) across England have been asked to review their current capital spending plans for 2019/20 to ensure that the national Capital Delegated Expenditure Limit (CDEL) can be delivered. TEWV has reviewed the options to reduce its current capital spending proposals as part of the North East and North Cumbria ICS process. TEWV has reduced its planned spend by £4.5m (9%) from £49.8m to £45.3m due to slippage on parts of the programme. This will not impact on delivery of the new York Hospital or plans to address the defects at Roseberry Park.

2. CQC Action Plan – 'Must Do' Actions

Further to previous discussions, assurance has been received from the Director of Quality Governance that all the 'must do' actions contained in the CQC action plan have been completed.

A report on this matter is therefore not included on the agenda for today's meeting.

3. Patient Safety Strategy

The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients was published in July 2019.
The strategy sets out what the NHS will do to achieve its vision to continuously improve patient safety.

4. Freedom to Speak up Index

At the 2018 National Freedom to Speak Up Conference, Simon Stevens presented preliminary findings from the NHS staff survey that he suggested could be used as a proxy measure of the Freedom to Speak Up culture in trusts.
Following analysis of the results of the most recent staff survey, TEWV have received communication from the National Freedom to Speak Up Guardian that we have recorded the equal highest score for Combined Mental Health/Learning Disability Trusts. Our score was 81% against an overall highest score across all Trusts of 87%.
It is likely that as a result, we will attract positive publicity around our inclusion in the report and how we compare with others and have also been invited to take part in the national launch of the index. Whilst this is good news, it remains an feature of our current crowd-sourcing conversations to further explore how staff can raise concerns in a safe way.

5. Summary of Long Tem implementation framework

In January, NHS England and NHS Improvement committed to publish an implementation framework for the NHS Long Term Plan, setting out further detail on how the commitments in that document will be delivered. The framework has been published today at: https://www.longtermplan.nhs.uk/implementation-framework/

Local systems will prepare draft versions of their five-year plans by mid-September, with final versions submitted by November 2019. These plans will later be published as part of a national implementation plan setting out key milestones and performance trajectories.

Colin Martin
Chief Executive

ITEM NO. 9

Trust Board of Directors

DATE:	**July 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 year 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. Junior Doctor engagement in processes has remained high. Careful consideration is being given to how best to make use of money provided to improve working conditions.

Recommendations:

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

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

1. INTRODUCTION & PURPOSE:

The Board receive Annual & quarterly reports from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for Junior Doctors. This report contains quarterly data in the appendices and 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, 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 newly introduced on-call log forms allow for further scrutiny of out of hours working to ensure appropriate schedules of employment.
- The majority of exception reports over the year have been placed for additional hours of work. I am satisfied that doctors are paid for work undertaken. There has been no justification to levy a fine on any department within the organisation. I am however aware that one doctor in Scarborough recently worked a 71 hour week and would have breached had they not fortuitously 'banked' 8 hours of 'time off in lieu' immediately prior to their on-call day. The Guardian has arranged to meet with the Locality Manager and the doctor concerned to look at this event.

- The on-call log form has been reviewed in both the Junior Doctor Forum and the Local Negotiating Committee and it was agreed to continue this process. Doctors will continue to submit exception reports in the usual way for all other work or if their night-time work breaches safety limits.
- The Harrogate & Northallerton Hybrid Resident system has been working well.
- The next Scarborough locality Junior Doctor Forum meeting has been brought forward in September in order that interim arrangements for weekend working can be reviewed to ensure doctors are working safely within contractual limits without compromising the service.
- Consideration will need to be given for the impact of Adult Mental Health bed 'decanting' to Sandwell Park on current Teesside rota configuration.
- A series of ward workshops are planned prior to trial in August of the on-call laptop system for work prioritisation in Tees.
- I would ask that consideration is given to Trust Doctors (similar contract) also holding laptops in order to complete on-call tasks remotely where appropriate.
- A flow diagram has been produced and implemented in York to allow local agreement to fill vacant resident night-shifts with non-resident locum doctors. Reassurance is needed that a similar process can be implemented in other areas where a similar practice is used.
- I continue to receive assurance that medical staffing have processes to ensure internal locums don't breach safe hours limits.
- All trusts have received £30k for improving working conditions in line with the fatigue and facilities charter. This money sits in the Guardian's budget line in order that the forum decide how best to spend this. An initial meeting has been held to discuss issues in each rota area and a further meeting is planned with Estates.
- There are concerns that Lone Working procedures are rarely followed and that an organisation-wide approach to this may be required.
- Our Champion of Flexible Working is due shortly to retire; this has proven to be extremely beneficial in supporting an increasing number of less than full time junior doctors and I ask the Board to support a replacement.
- Enclosed as Appendix 3 is a copy of 2019 feedback from Junior Doctors on the Guardian's performance. Junior Doctors have been tasked with scrutinising this feedback and offering guidance on any improvement actions at the next 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.
The high levels of exception reporting have been 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 & Medical Directorate 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.
Appendix 3: Guardian Feedback

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

High level data

Number of doctors / dentists in training (total):	86
Number of doctors / dentists in training on 2016 TCS (total):	84
Number of clinical supervisors	67
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 April 2019 up to 30th June 2019

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	1	1	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	0	0	0
CT1-2 Teesside & Forensic Services Juniors	0	5	5	0
CT1-2 –North Durham	0	15	15	0
CT1-2 – South Durham	0	0	0	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	37	37	0
CT3 – North Durham	0	5	5	0
CT3 – South Durham	0	0	0	0
ST4-6 –North & South Durham Seniors	0	0	0	0
Trust Doctors - North Durham	0	0	0	0
Trust Doctors - South Durham	0	0	0	0
Trust Doctors - Teesside	0	7	7	0
Total	**0**	**70**	**70**	**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	16	16	0
Teesside & Forensic Senior Registrars	0	31	31	0
North Durham Juniors	0	20	20	0
South Durham Juniors	0	0	0	0
South Durham Senior Registrars	0	0	0	0
Total	**0**	**67**	**67**	**0**

Hours monitoring exercises (for doctors on 2002 TCS only)					
Locality	**Grade**	**Rostered hours**	**Monitored hours**	**Banding**	**WTR compliant (Y/N)**
Teesside & Forensic Juniors	Not applicable as all junior doctors are on the new contract				
Teesside & Forensic Senior Registrars	ST6	33.5		FC(F8)	Yes
Teesside CAMHS	Not applicable as all Senior Registrars are on the new contract				
Durham & Darlington CAMHS	Not applicable as all Senior Registrars are on the new contract				
South Durham Juniors	Not applicable as all junior doctors are on the new contract				
South Durham Senior Registrars	Not applicable as all Senior Registrars are on the new contract				
North Durham Juniors	Not applicable as all junior doctors are on the new contract				
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	SAS	Old	Unknown	50	1	0	50	2
	CT3	New	Unknown		9			
	CT1	New	Unknown		9			
	MTI	New	Unknown		2			
	CT3	New	Unknown		2			
	SAS	Old	Unknown		6			
	SAS	Old	Unknown		1			
	TD	New	Unknown		9			
	CT2	New	Unknown		2			
	WAST	New	Unknown		4			
	F2	New	Unknown		2			
	CT3	New	Unknown		3			

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**
North Durham	CT1	New	Unknown	8	5	0	8	0
	SAS	N/A	Unknown		3			
South Durham	SAS	N/A	Unknown	12	3	0	12	0 (but an F2 with health restrictions that cannot do on-calls)
	MTi	N/A	Unknown		2			
	CT1	New	Unknown		1			
	SAS	N/A	Unknown		4			
	SPR	New	Unknown		1			
	SAS	N/A	Unknown		1			
Total				**70**	**70**	**0**	**70**	**2**

Narrative around Exception Reporting

Durham & Darlington

There were 20 exception reports received from the Durham and Darlington locality during the reporting period and that includes data from 5 rotas (South Durham junior doctors, North Durham junior doctors, South Durham Senior Registrars, North Durham Senior Registrars and D&D CAMHS Senior Registrars). All exception reports were from the North Durham junior doctor rota and 16 were in relation to claiming additional plain and enhanced time worked over the 8 week NROC period whereas 4 reports were for claiming TOIL for late finishes.

Teesside & Forensics

The level of locum cover is quite high due to 2 vacancies and 2 people being on long term sick or restricted duties. This is unavoidable as the vacancies and sickness occurred after the rota was published. The sickness is not related to work or rota stress. All of the exception reports (bar 3), were for work done in enhanced time. The junior doctors have 1 hour per week of plain time included in their schedules and previous exception reports/NROC forms show this is more than adequate. Senior registrars have 3 hours per shift included in their schedules and again, exception reporting/NROC forms have proved to be ample. The senior registrar exception reports are for MHA/S136 assessments which are unpredictable in number. The remaining 3 exception reports were related to extensions of the working day belonging to 2 people working with the same consultant during a time of staff annual leave. They were advised to speak to their consultant to take the time back.

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

High level data

Number of doctors / dentists in training (total):	60
Number of doctors / dentists in training on 2016 TCS (total):	60
Number of clinical supervisors	47
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:	0.125 PA per trainee

Exception reports (with regard to working hours) from 1st April 2019 up to 30th June 2019

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	0	0	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	0	0	0
CT1-2 - Harrogate	0	1	1	0
CT1-2 - Scarborough	0	21	21	0
CT1-2 - York	1	0	1	0
CT3/ST4-6 – Northallerton	0	0	0	0
CT3/ST4-6 – Harrogate	0	0	0	0
CT3/ST4-6 – Scarborough	0	2	2	0
CT3/ST4-6 – York	0	6	6	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	10	10	0
Trust Doctors - Scarborough	3	5	8	0
Trust Doctors - York	0	11	11	0
Total	**4**	**56**	**60**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton	0	0	0	0
Harrogate	0	11	11	0
Scarborough	3	28	31	0
York	1	17	18	0
Total	**4**	**56**	**60**	**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**
Harrogate & Northallerton	SAS	N/A	Unknown	47	47	0	47	2x WTE not doing out of hours on calls. 1x WTE on maternity leave 1x WTE joined rota partway through period
	SAS	N/A	No					
	SAS	N/A	Unknown					
	SAS	N/A	Unknown					
	CT1	New	No					
	CT1	New	Yes					
	CT2	New	No					
	ST2	New	No					
	CT3	New	Unknown					
	TD	New	No					
Scarborough	SAS	N/A	Unknown	18	18	0	18	1x WTE off the rota due to occ health reasons. 2x WTE joined rota partway through period
	SAS	N/A	Unknown					
	CT2	New	No					
	CT2	New	Unknown					
	ST4	New	Unknown					
	TD	New	Unknown					
York & Selby	CT2	New	No	14	14	0	14	1 x 0.6 WTE not working night shifts due to occ health reasons
	CT2	New	Unknown					
	CT2	New	Unknown					
	F2	New	Unknown					
	TD	New	No					
	SAS	N/A	Unknown					
Total				**79**	**79**	**0**	**79**	**0**

Narrative around Exception Reporting

York & Selby

There were 17 exceptions during the reporting period in the York & Selby locality. 6 exceptions were reported by a higher trainee in relation to on call work. The remainder of the exceptions were reported by two Trust Doctors who joined the locality in February. These were due to late finishes to the normal working day. There is one doctor who is not currently working night shifts (maternity risk assessment). The majority of locum shifts in this period have been due to sickness.

Scarborough

During the reporting period there were 28 exceptions from the Scarborough locality. The majority of these were due to on call work – either to claim payments following the submission on the NROC form or to claim toil while monitoring was ongoing. 2 exceptions were submitted as a result of late finish to the normal working day. Locum shifts have mainly been as a result of 1 x trust doctor not doing on call work following an occupational health review. At the start of this period 2 x trust doctors had not fully joined the rota, however are both participating fully now.

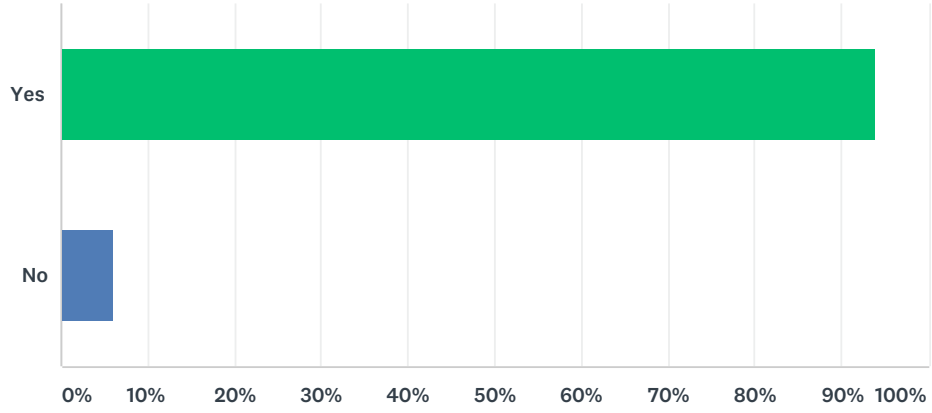
Harrogate & Northallerton

There were 11 exception reports raised during the reporting period in the Harrogate locality. 10 of these were as a result of late finishes to the normal working day. 1 of these was to report missing an educational event (weekly teaching in York) as a result of busy on call shift the night before. There were no exception reports raised by Northallerton doctors.

Locum shifts in Harrogate and Northallerton have arisen due to a number of different reasons. One GP registrar went on maternity leave in May. 2x GP registrars from Northallerton are not participating in out of hours on calls as they were given this option when the rotas merged in May. 1 Trust Doctor did not join the rota until the end of May and are still not yet participating fully in on calls.

Q1 Are you aware of who the ‘Guardian of Safe Working’ is?

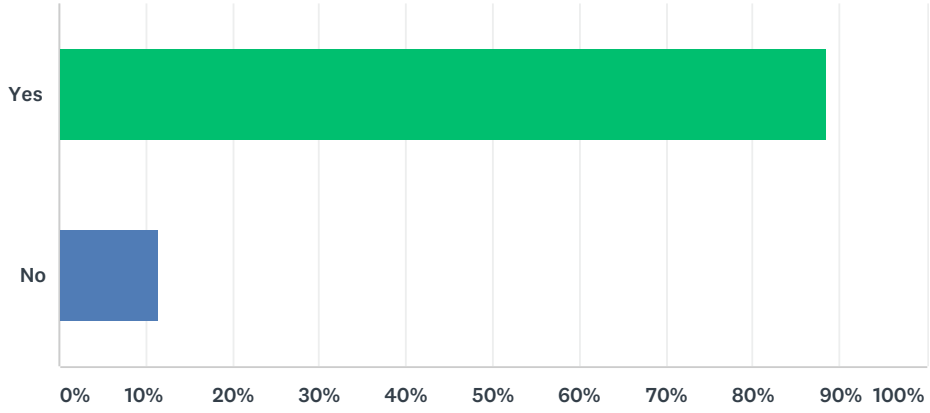
Answered: 33 Skipped: 2



ANSWER CHOICES	RESPONSES	
Yes	93.94%	31
No	6.06%	2
TOTAL		33

Q2 Do you know how to contact the ‘Guardian of Safe Working’?

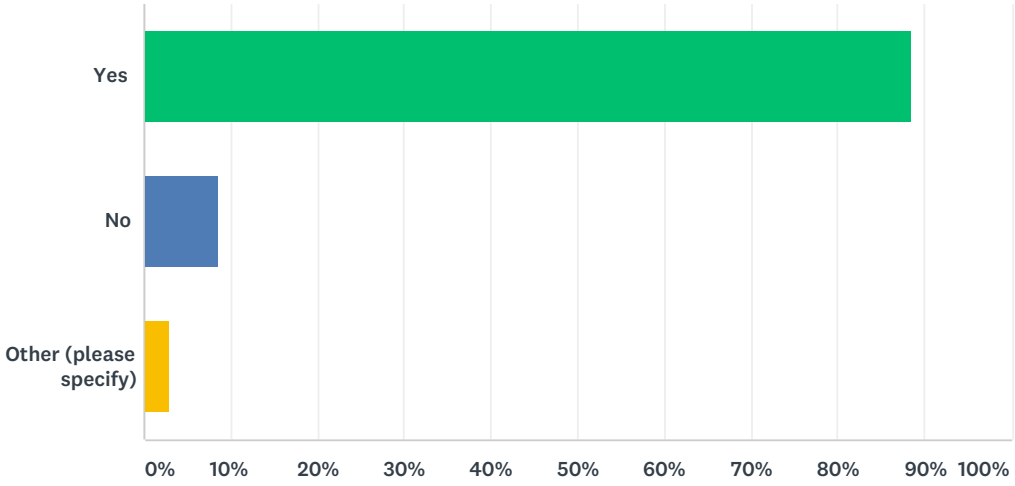
Answered: 35 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	88.57%	31
No	11.43%	4
TOTAL		35

Q3 Do you feel the ‘Guardian of Safe Working’ is Independent from the Trust in his role as Guardian?

Answered: 35 Skipped: 0

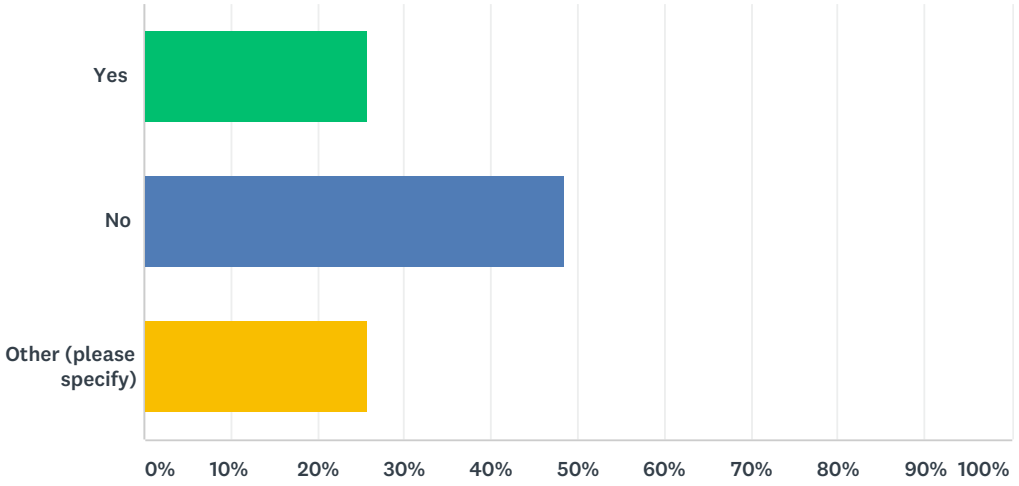


ANSWER CHOICES	RESPONSES	
Yes	88.57%	31
No	8.57%	3
Other (please specify)	2.86%	1
Total Respondents: 35		

#	OTHER (PLEASE SPECIFY)	DATE
1	Dont know	5/24/2019 8:45 PM

Q4 Do you see or get access to the reports produced for the Board of Directors by the ‘Guardian of Safe Working’?

Answered: 35 Skipped: 0

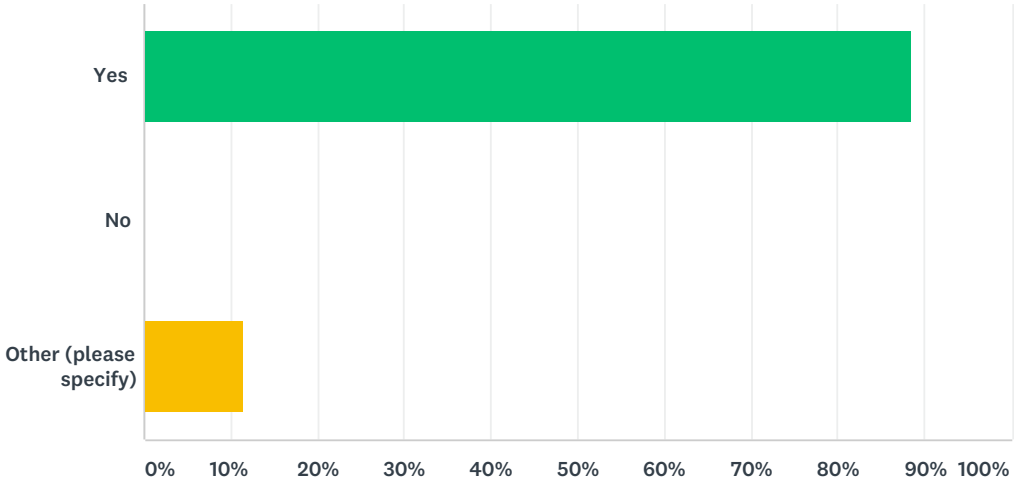


ANSWER CHOICES	RESPONSES	
Yes	25.71%	9
No	48.57%	17
Other (please specify)	25.71%	9
TOTAL		35

#	OTHER (PLEASE SPECIFY)	DATE
1	dont know	5/29/2019 3:46 PM
2	I can't specifically remember seeing any, but I may have seen it in passing	5/28/2019 9:34 AM
3	unsure	5/26/2019 10:23 AM
4	I am not sure	5/25/2019 11:05 AM
5	Not sure	5/24/2019 7:53 PM
6	Unsure	5/14/2019 11:29 AM
7	not sure	5/13/2019 9:55 PM
8	Unsure	5/13/2019 6:30 PM
9	I believe I would have access I asked for	5/13/2019 5:54 PM

Q5 Do you feel the ‘Guardian of Safe Working’ is responsible for protecting the safeguards outlined in the 2016 TCS?

Answered: 35 Skipped: 0

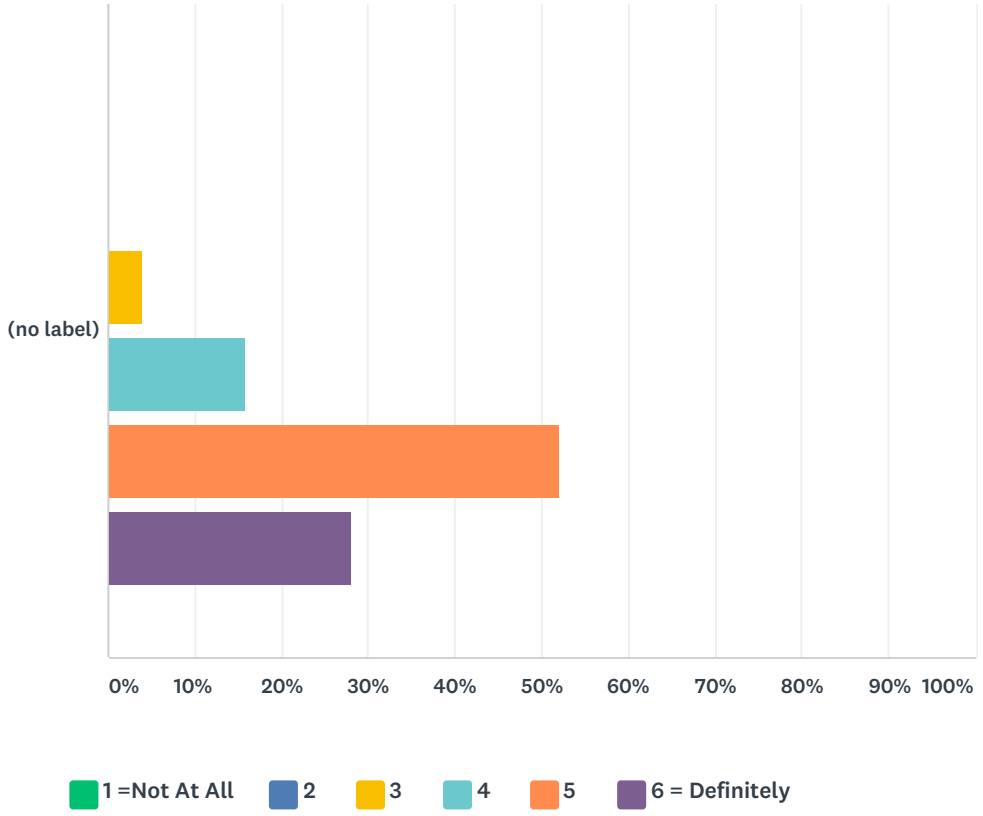


ANSWER CHOICES	RESPONSES	
Yes	88.57%	31
No	0.00%	0
Other (please specify)	11.43%	4
TOTAL		35

#	OTHER (PLEASE SPECIFY)	DATE
1	not sure	5/31/2019 7:30 PM
2	havent read it	5/26/2019 7:00 PM
3	I am not sure	5/25/2019 11:05 AM
4	not sure	5/13/2019 9:55 PM

Q6 Do you feel the ‘Guardian of Safe Working’ has dealt with issues of compliance effectively, in relation to safe working?

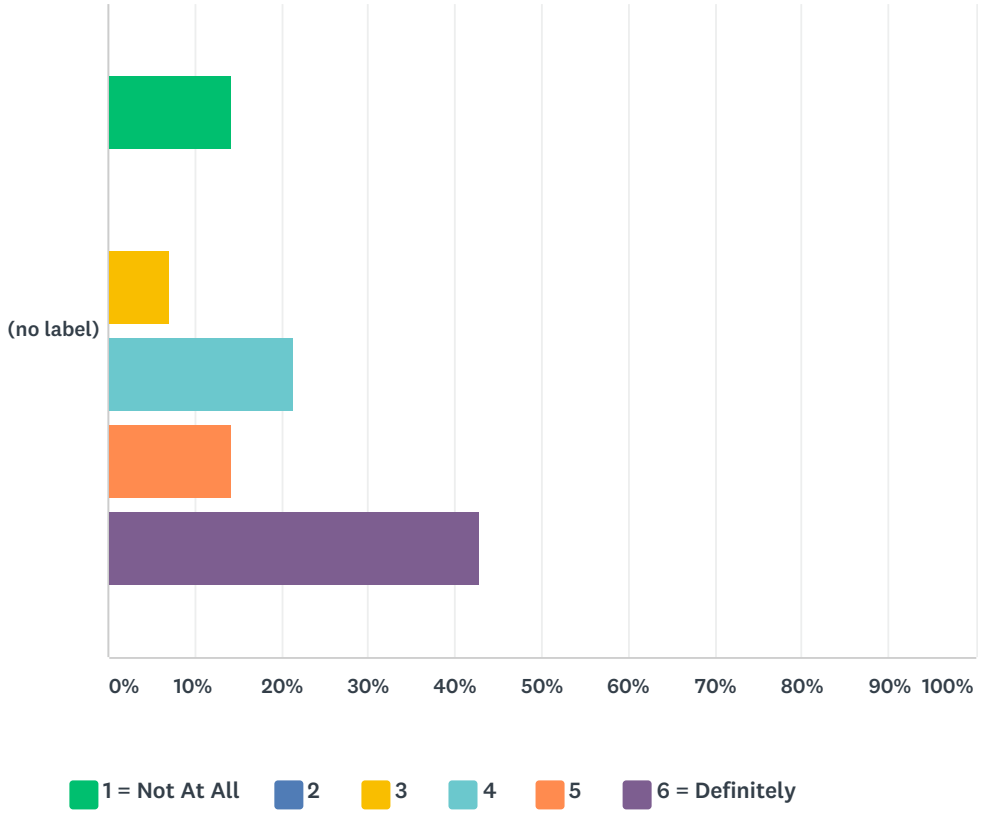
Answered: 25 Skipped: 10



	1 =NOT AT ALL	2	3	4	5	6 = DEFINITELY	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	4.00% 1	16.00% 4	52.00% 13	28.00% 7	25	5.04

Q7 If you have raised any issues with the ‘Guardian of Safe Working’ were they dealt with or answered appropriately?

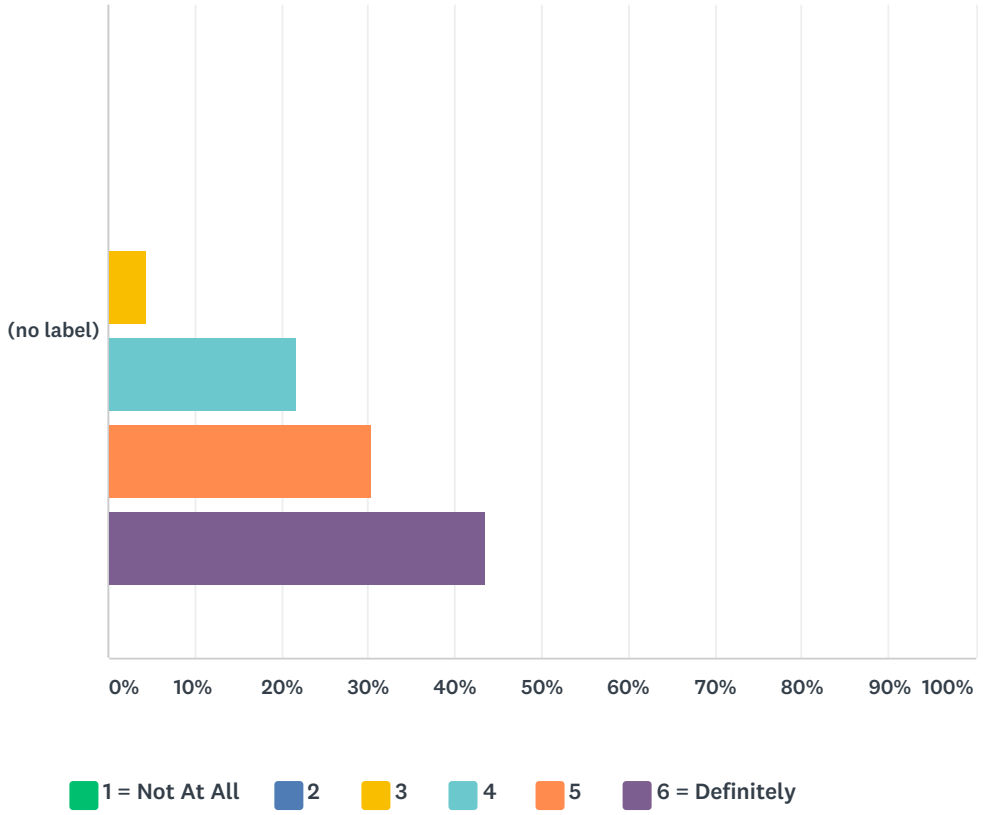
Answered: 14 Skipped: 21



	1 = NOT AT ALL	2	3	4	5	6 = DEFINITELY	TOTAL	WEIGHTED AVERAGE
(no label)	14.29% 2	0.00% 0	7.14% 1	21.43% 3	14.29% 2	42.86% 6	14	4.50

Q8 From either personal experience or from feedback from colleagues, do you feel any issues raised with the ‘Guardian of Safe Working’ are taken seriously?

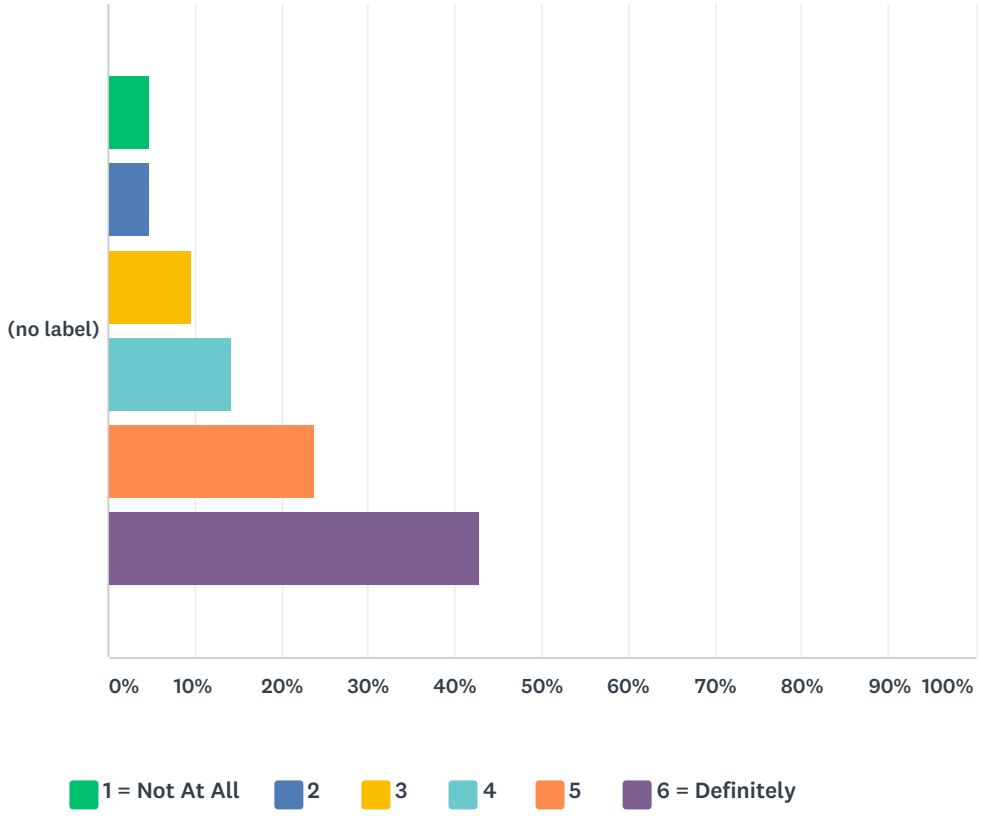
Answered: 23 Skipped: 12



	1 = NOT AT ALL	2	3	4	5	6 = DEFINITELY	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	4.35% 1	21.74% 5	30.43% 7	43.48% 10	23	5.13

Q9 Do you feel that any Exception Reports you have submitted have been dealt with appropriately?

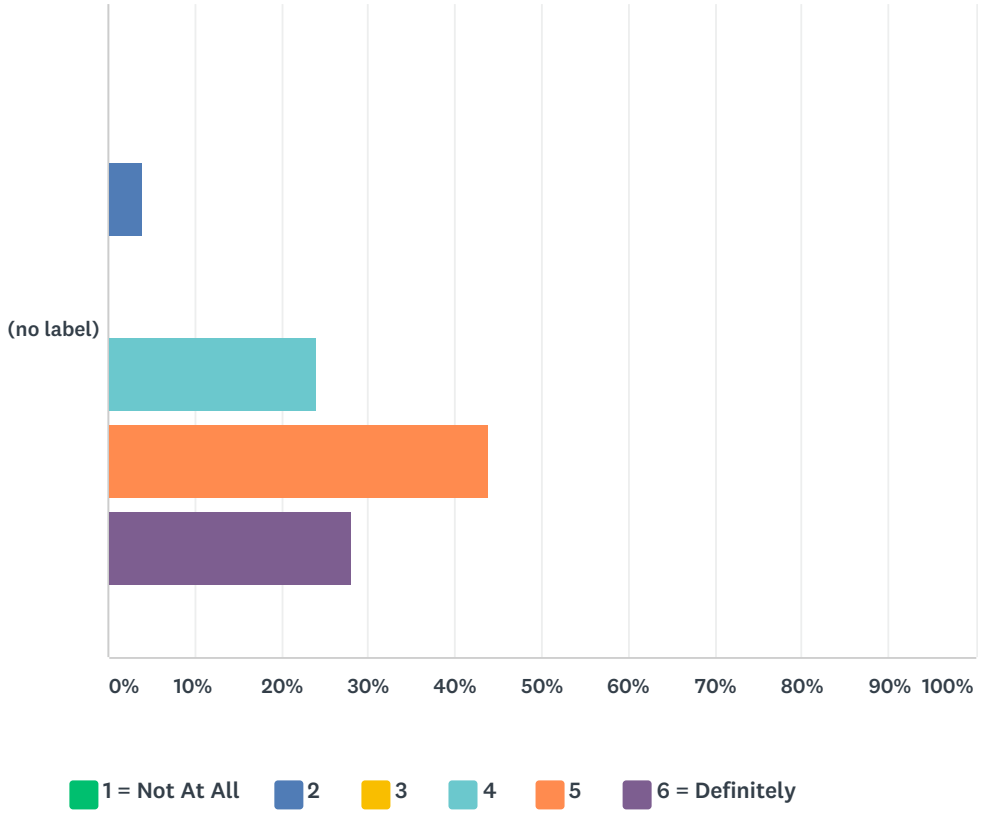
Answered: 21 Skipped: 14



	1 = NOT AT ALL	2	3	4	5	6 = DEFINITELY	TOTAL	WEIGHTED AVERAGE
(no label)	4.76% 1	4.76% 1	9.52% 2	14.29% 3	23.81% 5	42.86% 9	21	4.76

Q10 Are you confident that the ‘Guardian of Safe Working’ is managing the issues raised by junior doctors effectively?

Answered: 25 Skipped: 10



	1 = NOT AT ALL	2	3	4	5	6 = DEFINITELY	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	4.00% 1	0.00% 0	24.00% 6	44.00% 11	28.00% 7	25	4.92

Q11 Please provide any other feedback you would like to share about the Guardian of Safe Working.

Answered: 4 Skipped: 31

#	RESPONSES	DATE
1	.	5/24/2019 10:36 PM
2	Haven’t had involvement	5/24/2019 8:46 PM
3	.	5/24/2019 5:10 PM
4	I have not needed to have any particular contact so some questions not applicable.	5/24/2019 5:08 PM

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**18 July 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 December 2018 to 31st May 2019) 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 and compliance with Developing Workforce Safeguards (NHSI, 2018).

In summary, the report highlights the following:

- Changes to numbers of staff in post can be observed as follows:
  - Across all inpatient areas, a decrease of approximately 16.90 registered nurses and an increase of 19.30 WTE unregistered nurses in post.
- 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.
  - Harland Rehab (Durham & Darlington, Adults) as having the lowest fill rate of 36.3% for registered nurses on days. The low fill rate is as a result of the unit closing in January 2019 and then re-opening under Harland AMH as a single occupancy ward.
  - The second lowest fill rate utilising the 6 month average highlights Langley (Forensic LD) with a fill rate of 73.4% for registered nurses on Days. This is linked to vacancies within the unit. The ward has confirmed that a registered nurse has been allocated to each shift.
  - The third lowest fill rate utilising the 6 month average highlights Westwood Centre (Teesside, CYPS) with a fill rate of 73.7% for unregistered nurses on Days. This correlates with a reduction

in bed occupancy and HR processes impacting on staffing over the period.
  - Sickness is the biggest factor impacting on staffing with 40 wards (this is a reduction of 4 when compared to the previous 6 month report). Agency usage (29 wards) and Maternity (16 wards) were cited as the second and third highest.
  - 12,799 additional duties were created with a reason of 'enhanced observations'. This is a reduction of 1,386 duties when compared to the previous 6 month report. The 12,799 additional duties created would equate to 11,629 12 hour shifts.
  - Westerdale South was cited as the highest user of additional duties with a reason of 'enhanced observations'. They have now commenced recruitment to implement a 'zonal observation' pilot.
  - Bank usage greater than 25% equated to 14 wards in 4 separate localities. Brambling (Secure inpatient services) is the highest user with a bank fill rate of 34.7%.
  - Agency usage related to 28 wards in 4 separate localities. Cedar (NY) had the highest with an agency usage rate of 55.2%.
  - The majority of inpatient wards are using overtime to fill shifts however, those in excess of 4% equates to 14 wards. Teesside are using the most overtime whilst North Yorkshire is using the least.
  - There are 44 wards from all localities that have utilised bank, agency and overtime within the reporting period.

- 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 pending development of the dashboard expected 2019.

- Triangulation of quality data over the 6 month average:
  - 148 incidents were raised during the reporting period citing concerns with staffing levels. This is an increase of 19 when compared to the previous 6 month report (129 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 CHPPD across all inpatient areas was 10.5 (3.7 registered nurses; 6.7 healthcare assistants; 0 registered AHP and 0 unregistered AHP). Page 26 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 data.
- The Trust has been advised that its Monitor Risk rating has been impacted upon for 2018/19 by a breach of the Agency Cap. The Right Staffing Establishment Workstream Agency Project Group is working to reduce agency expenditure across the Trust for all staff groups i.e. nursing, medical AHP, and non-clinical roles such as admin and estates. - Reports to EMT and Board in Q1 2019/20 have relayed the current status.

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:	**18 July 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 December to 31st May 2019) 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 and subsequent service specific guidance for Learning Disability and Mental Health (NQB, 2018), and the recommendations from Developing Workforce Safeguards (NHSI, 2018).

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

2.3 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, NQB, 2016; NQB 2018) and Developing Workforce Safeguards guidance (NHSI, 2018) in addition to the broader aspects of the workforce identified in 2.4 of this report.

2.4 The Right Staffing programme board considers the broader multidisciplinary workforce for inpatient and community services 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, and reports to EMT and the Strategic Change Oversight Board.

2.5 The Right Staffing programme has four workstreams with associated projects and sub streams that considers developmental approaches alongside the task based aspects to ensure compliance with national guidelines, and are:

- Staffing Establishment Workstream

  - Temporary Staffing
  - E-Rosters
  - Staffing Establishment Reviews
  - Agency Project
- Recruitment and Retention Workstream
- Workforce Roles Workstream
- Training and Development Workstream

2.6 Guidance 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. The Right Staffing Programme Manager is a part of the national CNO Safe Staffing Faculty, which will be a vital resource in terms of networking and ensuring the Trust approach is up to date.

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

The new guidance builds upon the NQB guidelines (2016), and specific guidance for Learning Disability and Mental Health (NQB, 2018) and so existing Trust programme work is closely aligned to the new recommendations; this now provides the framework and basis for the current work within the programme.

3. 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 Staffing establishment reviews within the Trust have mostly been on an as required basis following forecast service changes, escalation of issues, and the continuing and ongoing process of local and trust wide governance and assurance reporting. Previous review of inpatient services using an evidence based tool (EBT) revealed key learning points, but nevertheless had proven a valuable exercise and resulted in significant investment from the Trust in key areas. Learning is taken forward from this previous exercise, supported by the Developing Workforce Safeguards guidance (NHSI 2018) and the improvements to the EBT, the Mental Health Optimal Staffing Tool (MHOST) – now licensed to the Trust - into the establishment review process. Right Staffing is leading and supporting pilot sites in York AMH with MHOST and the establishment review process; additionally with KPO in delivering the Trust wide series of Kaizen events across all clinical services and localities; this is for all staff groups in the MDT, operational and clinical management, for both inpatient and community services.

3.1.3 Professor Keith Hurst author of MHOST and community evidence based tool has visited the Trust on request to deliver a workshop on the community tool with a pilot group of Community teams (Affective, Psychosis, MHSOP and EIP), Crisis and Liaison teams in the Durham and Darlington, and Crisis Teams from Tees side and North Yorkshire; the outcomes are to be evaluated with teams in Q2 2019/20 to determine validity of the tool in the teams, with a view for a potential Trust wide roll out in 2020.

3.1.4 Kaizen events remain ongoing for July 2019, with MHOST data collection to commence September 2019, and formal establishment reviews October 2019. This will be on a rolling 6 monthly basis and will comply with NHSI requirements.

3.1.3 As an interim approach the budgeted staffing establishments as at 1st December and the 31st May 2019 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 2.4 WTE and an increase of 3.2 WTE unregistered nurses can be observed. The increases in registered nurses pertain to Birch whilst the increases in unregistered nurses pertain to Hamsterley Ward.
- Forensic Services – registered nurses in post has increased by 1.9 WTE and an increase of 6.30 WTE for unregistered nurses. The increases in registered nurses relate to Nightingale, Swift, Northdale and Oakwood. The increases in unregistered nurses relate mainly to Newtondale.
- North Yorkshire – registered nurses in post has increased by 0.2 WTE and an increase of 16 WTE unregistered nurses. The increases are across the service.
- Teesside – registered nurses in post has decreased by 14.1 WTE and 7.30 WTE less unregistered nurses. The Lodge, Thornaby Road, Newberry, Evergreen and Lustrum Vale were cited for having the highest reduction of registered nurses. The Lodge and Westerdale South had the highest reduction of unregistered nurses.
- York and Selby – registered nurses in post have decreased by 7.3 WTE and an increase of 1.1 WTE unregistered nurses. The reduction of registered nurses relate to Meadowfields, Ebor and Acomb Garth. The increase in unregistered nurses relate to Oak Rise and Minster.

- Across all inpatient areas, this has resulted in a decrease of approximately 16.90 registered nurses and an increase of 19.30 WTE unregistered nurses in post.

3.1.4 Since May 2018 the Trust has been participating in a national collaborative programme led by NHS Improvement. All mental health and learning disability trusts are participating in this programme and the Trust is in cohort three. We have recently received staff retention related data, up to September 2018, from NHS Improvement comparing the Trusts position with that of other mental health and learning disability trusts within the north east and Yorkshire region. The TEWV clinical staff labour turnover rate was lower than the average of other mental health and learning disability trusts within the region throughout 2018 though the TEWV rate increased from 9.7% to 10.5% during this time compared to an average rate of 11%.

3.1.5 The NHS Improvement data also included an analysis of the 2018 staff survey results of staff engagement levels, flexible working opportunities, the quality of appraisal and staff working extra hours. Each of these four issues is believed to impact upon staff retention. The TEWV results in the 2018 survey were better than in 2017 in respect of all four issues. When compared to the average scores of the comparator trusts TEWV scores were better with regard to three of the four issues, the exception being staff working extra hours. There is little difference between TEWV and its comparator trusts with regard to the reasons for leaving and the proportion of staff that are leaving for these reasons. The Trust submitted a retention action plan as required by NHS Improvement in July 2018 as part of the wider TEWV Recruitment and Retention Action Plan which described a number of key actions focused upon improving staff retention. It was agreed with NHS Improvement prior to submitting the retention plan that there ought to be a particular focus upon the North Yorkshire and York locality given the higher than average labour turnover rates and the lower than average recruitment fill rates compared to other TEWV localities. A range of new processes have been consulted upon and agreed to improve retention and work is underway to embed these processes.

3.1.6 A workstream has also been established to lead the work on understanding and correcting the Trust's agency staffing position, under the staffing establishment group of the Right Staffing programme, chaired by the Chief Operating Officer. The board was recently provided with an update about actions being planned and taken to reduce agency spend.

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 In May 2019 there were no wards who reported less than 75% compliance for mandatory training. The lowest level of compliance in May 2019 is reporting at 87.20% and related to Ward 15 (Adults). The planned closure of the unit would have impacted upon this.

3.2.3 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. Previously a risk was identified regarding the varying timetables for this across the AEI providers; however there has been considerable joint working to manage this and it will continue to be monitored as we move into the transition phase. There is also a more standardised approach to assessment emerging across the region. Support from service colleagues is required to facilitate the communication of these new arrangements across the organisation. The new standards will potentially enable the Trust to support more nurse learners in practice which will assist with future recruitment however this will require senior management support in order to free up placement capacity. HEE are taking a close interest in the ability of Trusts to increase their training placements. The Professional Nursing team are devising a communication and training plan in conjunction with the Universities to help embed the new approaches.

3.2.4 The Trust Professional Nurse Education team and service based colleagues have been working jointly with the various Universities over this period to support their re-approval events with the Nursing and Midwifery Council for the new programmes, which to date has been a successful approach with a small number of events still remaining. The NMC have commented on the quality of the joint working evidenced at these events.

3.2.5 Within this approach, the Coventry University at Scarborough facility has recently been approved by the NMC at a joint event, to provide Mental Health and Learning Disability nurse training, this is a major development for the area and will raise the possibility of the Trust supporting staff as apprentices from the North Yorkshire area on to their registered nurse training, in addition to the extra numbers of students the University will recruit through normal routes. We envisage around 20 Mental Health students and a small number of learning disability students will emerge each year from the programmes in the future, which could increase further once established, and will ultimately help to address the recruitment and bank and agency issues in the area.

3.2.6 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.

3.2.7 The Trust continues to invest in the 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. Our first cohort of Nursing Associates qualified in April of this year and entered onto the NMC register. First-destination posts were found for these colleagues after a process of reviewing suitable employment and

development options which was approved at EMT. We have two further cohorts, currently in training, and there has been approval from the Executive Management team to continue to develop these roles further and support up to 25 further trainees within this financial year. As a further development, the Nursing Associate programme for Coventry University has been approved at a recent event, and we are continuing our partnership working with University of York which has also worked with the Trust to be recently approved by the NMC. . These developments will enable the Nursing Associate programme to expand into other areas of the Trust, as previously this has been Teesside and Durham focused owing to previous external funding and course approval arrangements.

3.2.8 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. These new roles will contribute to our development of strong cross professional clinical leadership as we move into collective models of leadership with our operational colleagues. QIAs will be in place for all these new roles in accordance with NHSI compliance requirements as stated in Developing Workforce Safeguards (NHSI, 2018).

3.3 Right place and right time

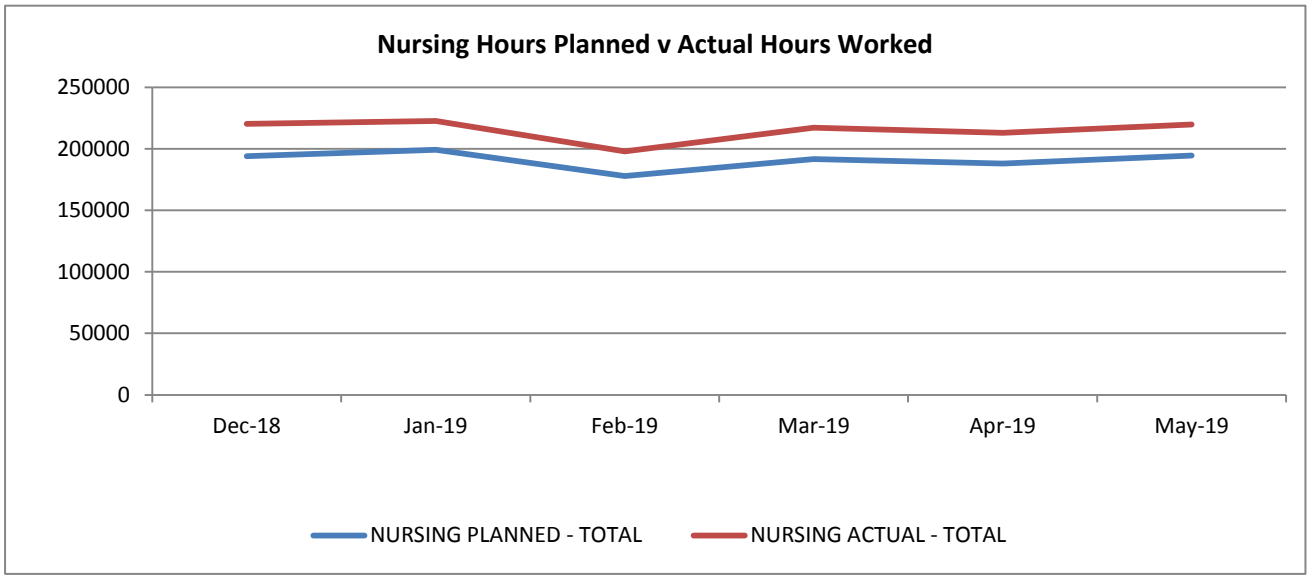
3.3.1 The NQB guidance states that Boards should ensure staff is deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise.

3.3.2 Within this domain, the Trust has developed a programme of annual reviews of the usage of the Health Roster system. Reviews have been completed for 2018/19, summary report to be delivered to services. Current work ongoing regarding the 2019/20 for the roster reviews which will utilise the successful workbook format seen last year.

3.3.3 Issues highlighted from roster reviews and current data quality issues informed the decision by EMT to increase the central roster resource to lead the longer term solution of embedding the review process, and the ongoing support for the governance of data quality for rosters into Business as usual practice.

3.3.4 A re-procurement exercise for Health Roster has been approved at EMT to consider the options of achieving the right and cost effective software solution that meets the Trust requirements for e-rostering and e-job planning. Further within this approach, the organisation has developed Escalation procedures in both in-patient and community settings, which are discussed in section 3.5

3.3.5 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:



3.3.6 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.

3.3.7 Appendix 3 of the report shows the average fill rate (1st December 2018 to 31st May 2019) for both days and nights for both registered and non-registered staff. The 6 monthly position shows that there were 18 (26%) fill rates of less than 89.9% (shown as red) for registered nurses on daytime shifts. In terms of unregistered nurses this equated to 6 (9%) 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.

3.3.8 In terms of the night time shifts the 6 monthly position shows that there were 8 (12%) fill rates of less than 89.9% (shown as red) for registered nurses and unregistered nurses there were 4 (6%) fill rates ward who had a fill rate below 89.9%.

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

Month	Actual Submission							
	Day				Night			
	Average Fill	Trend on	Average	Trend on	Average Fill	Trend on	Average	Trend on

	Rate - Registered Nurses / Midwives (%)	Prev Month	Fill Rate - Care Staff (%)	Prev Month	Rate - Registered Nurses / Midwives (%)	Prev Month	Fill Rate - Care Staff (%)	Prev Month
Dec-18	97.00	↓	117.10	↓	102.40	↑	134.00	↓
Jan-19	94.90	↓	117.20	↑	103.10	↑	128.80	↓
Feb-19	92.60	↓	116.50	↓	104.30	↑	129.70	↑
Mar-19	95.50	↑	117.00	↑	102.40	↓	134.40	↑
Apr-19	96.60	↑	117.80	↑	103.50	↑	131.80	↓
May-19	95.20	↓	117.90	↑	103.60	↑	131.80	→

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 decreased from 97.0% in December 2018 when compared to 95.2% in May 2019 (1.8% decrease).
- The average fill rate for health care assistants on day shifts has increased from 117.1% in December 2018 when compared to 117.9% in May 2019 (0.8% increase).
- The average fill rate for registered nurses on night shifts has improved from 102.4% in December 2018 when compared to 103.6% in May 2019 (1.2% increase).
- The average fill rate for health care assistants on night shifts has decreased from 134.0% in December 2018 when compared to 131.8% in May 2019 (2.2% increase).

3.3.10 The overall total red rated occurrences utilising the average fill rate (i.e. less than 89.9%) was 28 occurrences. The table below shows the breakdown by locality:

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

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

3.3.11 The 6 month average highlights Harland Rehab (Durham & Darlington, Adults) as having the lowest fill rate of 36.3% for registered nurses on days. The low fill rate is as a result of the unit closing in January 2019 and then re-opening under Harland AMH as a single occupancy ward.

3.3.12 The second lowest fill rate utilising the 6 month average highlights Langley (Forensic LD) with a fill rate of 73.4% for registered nurses on Days. This is linked to vacancies within the unit. The ward has confirmed that a registered nurse has been allocated to each shift.

3.3.13 The third lowest fill rate utilising the 6 month average highlights Westwood Centre (Teesside, CYPS) with a fill rate of 73.7% for unregistered nurses on Days. This is due to a reduction in bed occupancy and HR processes impacting on staffing availability.

3.3.14 The Lodge has been discounted from the low fill rate analysis due to the transition to a private provider.

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

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

3.3.16 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.

3.3.17 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
December	2466	26,855.00
January	2321	25,169.00
February	2013	21,802.00
March	2085	22,703.00
April	1871	20,632.00
May	2043	22,387.00
TOTAL	**12,799**	**139,548**

- 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 1,871 to 2,466 across the period)

- 12,799 additional duties/shifts were created within the reporting period this is a decrease of 1,386 duties when compared to the previous 6 month period.

- The 12,799 additional duties/shifts created equating to 139,548 hours within the reporting period this is a reduction of 11,455 hours when compared to the previous 6 month period. The additional 139,548 hours created would equate to 11,629 12 hour shifts.

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

Locality	Ward / Team	Number of Duties	Number or Hours
Teesside	Westerdale South	1144	12749
Forensic	Mandarin	694	7532
Durham & Darlington	Hamsterley Ward	590	6532
York & Selby	Acomb Garth	580	6623
Durham & Darlington	Holly Unit	521	4449
Teesside	Lustrum Vale	494	5610
Teesside	The Evergreen Centre	484	5502
Forensic	Merlin Ward	480	5215
Forensic	Kestrel/Kite.	471	4412
Forensic	Mallard Ward	458	5017
	TOTAL	**5916**	**63640**

3.3.19 Following approval of a report at EMT regarding proposed use of the Zonal Engagement and Observation model for MHSOP organic inpatient wards, Westerdale South (Teesside) are proceeding and expect to be operational with this practice by Q2 2019/20. Acomb Garth (North Yorkshire and York) will consider adopting the model for the new hospital following evaluation of an approved staffing increase and merger with Meadowfields. Both wards will be monitored by the metrics detailed in the proposal and overseen by the Right Staffing Establishment workstream and programme board.

3.3.20 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:

Ward Name	Locality	Speciality	Bank (Nursing)	
			Hours	% loss against Actual Hours
Brambling	Forensics	Forensics MH	7151.0	34.7%
Lustrum Vale	Teesside	Adults	7590.5	33.3%
Kestrel / Kite.	Forensics	Forensics LD	8665.1	32.9%
Northdale Centre	Forensics	Forensics LD	9657.1	32.4%
Mandarin	Forensics	Forensics MH	7592.2	32.0%
Westerdale South	Teesside	MHSOP	9384.9	30.6%

Birch Ward	Durham & Darlington	Adults	6510.6	31.0%
Clover / Ivy	Forensics	Forensics LD	6631.3	29.9%
Mallard	Forensics	Forensics MH	6527.0	26.8%
Maple	Durham &Darlington	Adults	5435.4	26.4%
Merlin	Forensics	Forensics MH	6654.8	25.8%
Rowan Lea	North Yorkshire	MHSOP	6841.0	25.2%
Westwood Centre	Teesside	CYPS	6555.0	25.1%
Lark	Forensics	Forensics MH	4591.9	25.1%

- This equates to 14 wards in 4 separate localities.

3.3.21 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.

3.3.22 For 2018/19 the Trust's (TEWV) ceiling (NHSI agency cap) was £5,789k (1.95% of pay budget); the actual spend was £9,541k, i.e. 65% above target and as such provided a Use of Resource Rating (UoRR) of 4 for agency expenditure. As a result of this rating, this means that the Trust's has an overall UoRR for 2018/19 that is now capped at a rating of 3 despite the good performance in all other indicators in the UoRR in the Single Oversight Framework. The Trust target is a rating of 1 which would indicate that the Trust is below its agency ceiling, which has been increased by £834k to £6,623k for 2019/20.

3.3.23 A review was undertaken across the Trust using a nationally approved diagnostic tool and framework, which included a desktop data analysis and review, in conjunction with a series of staff engagements to determine the drivers and a better understanding for the agency spend in the Trust; this has formed the basis of an action plan. A recent NHSI consultation document published in June 2019 has highlighted the need to expedite certain actions relating to non-clinical staff and non-registered clinical staff; however a supportive relationship with NHSI remains in place, and their recommended actions built into the action plan.

3.3.24 The Trust continues to work collaboratively with NHSI, and are meeting 22nd August 2019 for further discussions. EMT and the Trust Board have received reports highlighting the current status of agency expenditure and current plans. Right Staffing has taken forward actions as recommended by the Board.

In terms of 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:

Ward Name	Locality	Speciality	Agency (Nursing)	
			Hours	% loss against Actual Hours
Cedar (NY)	North Yorkshire	Adults	11003.1	55.2%

Acomb Garth	York and Selby	MHSOP	12011.3	42.3%
Rowan Ward	North Yorkshire	MHSOP	8754.9	36.8%
Meadowfields	York and Selby	MHSOP	6698.0	32.4%
Cherry Tree House	York and Selby	MHSOP	4003.3	19.5%
Oak Rise	York and Selby	LD	5211.0	19.0%
Ward 15	North Yorkshire	Adults	1637.8	18.8%
Rowan Lea	North Yorkshire	MHSOP	4400.6	16.2%
Evergreen Centre	Teesside	CYPS	5110.2	15.8%
Springwood	North Yorkshire	MHSOP	3391.0	15.4%
Bedale Ward	Teesside	Adults	3234.7	12.0%
Ebor Ward	York and Selby	Adults	2053.0	12.4%
Minster Ward	York and Selby	Adults	2068.5	12.2%
Westerdale South	Teesside	MHSOP	3658.5	11.9%
Westerdale North	Teesside	MHSOP	2416.3	11.3%
Bek-Ramsey Ward	Durham &Darlington	LD	2055.5	7.6%
Overdale	Teesside	Adults	1251.5	7.3%
Newberry Centre	Teesside	CYPS	1813.1	7.3%
Hamsterley	Durham &Darlington	MHSOP	1853.7	7.3%
Ayckbourn Esk Ward	North Yorkshire	Adults	1153.0	7.2%
Maple	Durham &Darlington	Adults	1415.6	6.9%
Ward 14	North Yorkshire	MHSOP	456.8	6.8%
Lustrum Vale	Teesside	Adults	1435.5	6.3%
Birch Ward	Durham &Darlington	Adults	1245.3	5.9%
Oak Ward	Durham &Darlington	MHSOP	1054.1	5.8%
Stockdale	Teesside	Adults	910.5	5.7%
Elm Ward	Durham & Darlington	Adults	966.2	5.1%
Bilsdale	Teesside	Adults	696.5	4.4%

- This equates to 28 wards in 4 separate localities with noticeably higher use in NY and York localities, it is recognised that this is impacted on by the ability to recruit in that area as well as the limited availability of bank staff and higher staff turnover

3.3.25 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:

Ward Name	Locality	Speciality	Overtime (inc AHPs)	
			Hours	% loss against Actual Hours
Holly	Durham & Darlington	CYPS	1742.55	16.9%
Newberry Centre	Teesside	CYPS	1851.25	7.5%
Bek-Ramsey Ward	Durham & Darlington	LD	1908.74	7.0%
Bankfields Unit 2	Teesside	LD	614.58	5.7%
Bankfields Court	Teesside	LD	2375.45	5.3%

Oak Rise	York and Selby	LD	1314.09	4.7%
Minster Ward	York and Selby	Adults	848.5	4.7%
Baysdale	Teesside	CYPS	726.79	4.6%
Westwood Centre	Teesside	CYPS	1220.73	4.6%
Oakwood	Forensics	Forensics LD	601.73	4.6%
Harland Rehab Ward	Durham &Darlington	Rehab	89.33	4.4%
Thornaby Road	Teesside	Day Unit	492.1	4.3%
Cherry Tree House	York and Selby	MHSOP	932.88	4.2%
Swift Ward	Forensics	Forensics MH	748.58	4.1%

- The majority of the inpatient wards across the trust are using overtime.
- Teesside are using the most overtime (13,389) whilst North Yorkshire is using the least (3,525).
- There are 44 wards who have utilised bank, agency and overtime within the reporting period as outlined below:

Ward Name	Locality	Speciality	Overtime usage Vs actual Hours	Agency usage Vs actual Hours	Bank usage Vs actual Hours
Danby Ward	North Yorkshire	Adults	3.9%	3.3%	16.4%
Esk Ward	North Yorkshire	Adults	0.6%	7.2%	10.9%
Bedale Ward	Teesside	Adults	3.5%	12.0%	13.2%
Bilsdale	Teesside	Adults	3.2%	4.4%	11.6%
Birch Ward	Durham & Darlington	Adults	1.1%	5.9%	31.0%
Bransdale	Teesside	Adults	1.4%	4.0%	10.5%
Cedar	Durham & Darlington	Adults	1.8%	2.2%	22.6%
Cedar (NY)	North Yorkshire	Adults	1.3%	55.2%	7.0%
Ebor Ward	York and Selby	Adults	1.5%	12.4%	9.8%
Elm Ward	Durham & Darlington	Adults	2.2%	5.1%	22.2%
Farnham Ward	Durham & Darlington	Adults	0.6%	2.9%	5.5%
Kirkdale	Teesside	Adults	3.9%	3.0%	24.2%
Lustrum Vale	Teesside	Adults	1.7%	6.3%	33.3%
Maple	Durham & Darlington	Adults	1.5%	6.9%	26.4%
Minster Ward	York and Selby	Adults	4.7%	12.2%	5.7%
Overdale	Teesside	Adults	3.3%	7.3%	7.8%
Stockdale	Teesside	Adults	2.4%	5.7%	17.2%
The Orchards (NY)	North Yorkshire	Adults	2.7%	2.0%	7.6%
Tunstall Ward	Durham & Darlington	Adults	1.8%	3.0%	6.8%
Ward 15	North Yorkshire	Adults	1.2%	18.8%	21.3%
Willow Ward	Durham & Darlington	Adults	1.8%	1.4%	17.2%
Holly	Durham & Darlington	CYPS	16.9%	0.5%	21.1%
Newberry Centre	Teesside	CYPS	7.5%	7.3%	14.3%
Evergreen Centre	Teesside	CYPS	2.6%	15.8%	19.1%
Westwood Centre	Teesside	CYPS	4.6%	1.9%	25.1%
Clover / Ivy	Forensics	FLD	1.2%	0.1%	29.9%

Harrier / Hawk	Forensics	FLD	4.0%	0.1%	17.5%
Kestrel / Kite.	Forensics	FLD	1.7%	2.2%	32.9%
Langley	Forensics	FLD	0.8%	0.8%	10.9%
Northdale Centre	Forensics	FLD	3.4%	0.1%	32.4%
Bek-Ramsey Ward	Durham & Darlington	LD	7.0%	7.6%	13.0%
Oak Rise	York and Selby	LD	4.7%	19.0%	12.3%
Acomb Garth	York and Selby	MHSOP	0.5%	42.3%	6.4%
Ceddesfeld	Durham & Darlington	MHSOP	2.2%	3.4%	6.5%
Cherry Tree House	York and Selby	MHSOP	4.2%	19.5%	10.6%
Hamsterley	Durham & Darlington	MHSOP	1.0%	7.3%	13.7%
Meadowfields	York and Selby	MHSOP	1.9%	32.4%	21.0%
Oak Ward	Durham & Darlington	MHSOP	1.6%	5.8%	8.7%
Rowan Lea	North Yorkshire	MHSOP	2.6%	16.2%	25.2%
Rowan Ward	North Yorkshire	MHSOP	1.1%	36.8%	9.6%
Springwood	North Yorkshire	MHSOP	2.9%	15.4%	13.1%
Ward 14	North Yorkshire	MHSOP	3.5%	6.8%	13.9%
Westerdale North	Teesside	MHSOP	1.7%	11.3%	9.1%
Westerdale South	Teesside	MHSOP	0.9%	11.9%	30.6%

- 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 12 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 Name	Bank Usage	Agency Usage	Staffing Fill Rate			
				RN Days	RN Nights	HCA Day	HCA Night
1	Elm Ward	22.2%	5.1%	**102.4%**	**103.0%**	**93.3%**	**116.1%**
1	Overdale	7.8%	7.3%	**97.4%**	**102.3%**	**126.0%**	**127.9%**
1	Stockdale	17.2%	5.7%	**99.3%**	**100.8%**	**110.8%**	**115.3%**
1	Willow Ward	17.2%	1.4%	**111.3%**	**101.4%**	**128.0%**	**105.1%**
1	Evergreen Centre	19.1%	15.8%	**80.1%**	**108.4%**	**133.6%**	**179.1%**

1	Acomb Garth	6.4%	42.3%	**78.6%**	**95.7%**	**124.1%**	**190.3%**
1	Ceddesfeld	6.5%	3.4%	**99.3%**	**100.6%**	**118.7%**	**116.4%**
1	Cherry Tree House	10.6%	19.5%	**100.4%**	**105.5%**	**112.8%**	**148.2%**
1	Hamsterley	13.7%	7.3%	**104.0%**	**100.5%**	**174.2%**	**179.4%**
1	Rowan Lea	25.2%	16.2%	**89.1%**	**100.4%**	**157.5%**	**141.9%**
2	Westerdale North	9.1%	11.3%	**102.4%**	**107.8%**	**121.7%**	**157.8%**

- From those wards that did have an SI within the reporting period Rowan Lea, Acomb Garth and Evergreen reported a 'red' fill rate for registered nurses on days. All other fill rates are reporting as either 'green' or 'blue'.
- There was only Rowan Lea that reported as 'red' for their bank usage.
- All but 2 wards are reporting as 'red' for their agency usage.

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 1 case reviewed at Directors Panel which highlighted a contributory finding regarding staffing:

- 2019/1292 – The report highlights that there were some issues relating to low staffing that required frequent use of bank staff.

3.4.3 There were a total of 6 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 Name	Bank Usage	Agency Usage	Staffing Fill Rate			
				RN Days	RN Nights	HCA Day	HCA Night
1	Minster Ward	5.7%	12.2%	**99.7%**	**99.2%**	**99.2%**	**108.4%**
1	Overdale	7.8%	7.3%	**97.4%**	**102.3%**	**126.0%**	**127.9%**
1	Acomb Garth	6.4%	42.3%	**78.6%**	**95.7%**	**124.1%**	**190.3%**
1	Cherry Tree House	10.6%	19.5%	**100.4%**	**105.5%**	**112.8%**	**148.2%**
1	Rowan Lea	25.2%	16.2%	**89.1%**	**100.4%**	**157.5%**	**141.9%**
1	Westerdale North	9.1%	11.3%	**102.4%**	**107.8%**	**121.7%**	**157.8%**

- From those wards that did have a L4 incident Acomb Garth and Rowan Lea reported a 'red' fill rate for registered nurses on Days. All other fill rates are reporting as either 'green' or 'blue'.
- There was only Rowan Lea that reported as 'red' for their bank usage.
- All wards are reporting as 'red' for their agency usage.

3.4.4 There were 54 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 Name	Bank Usage	Agency Usage	Staffing Fill Rate			
				RN Days	RN Nights	HCA Day	HCA Night
9	Esk Ward	10.9%	7.2%	**80.8%**	**102.0%**	**128.1%**	**110.7%**
3	Birch Ward	31.0%	5.9%	**91.3%**	**101.1%**	**140.8%**	**141.6%**
1	Bransdale	10.5%	4.0%	**100.8%**	**102.7%**	**109.9%**	**107.9%**
2	Cedar	22.6%	2.2%	**102.6%**	**103.4%**	**102.1%**	**101.6%**
3	Cedar (NY)	7.0%	55.2%	**82.7%**	**138.3%**	**148.2%**	**108.7%**
3	Ebor Ward	9.8%	12.4%	**94.5%**	**98.9%**	**84.2%**	**104.2%**
10	Elm Ward	22.2%	5.1%	**102.4%**	**103.0%**	**93.3%**	**116.1%**
1	Farnham Ward	5.5%	2.9%	**92.5%**	**104.4%**	**153.7%**	**117.3%**
1	Lustrum Vale	33.3%	6.3%	**94.4%**	**101.8%**	**187.4%**	**175.1%**
2	Maple	26.4%	6.9%	**89.3%**	**104.7%**	**131.3%**	**161.5%**
3	Overdale	7.8%	7.3%	**97.4%**	**102.3%**	**126.0%**	**127.9%**
2	Tunstall Ward	6.8%	3.0%	**111.7%**	**103.3%**	**119.1%**	**117.9%**
3	Newberry Centre	14.3%	7.3%	**101.1%**	**119.5%**	**133.1%**	**183.6%**
1	Evergreen Centre	19.1%	15.8%	**80.1%**	**108.4%**	**133.6%**	**179.1%**
6	Westwood Centre	25.1%	1.9%	**74.0%**	**73.7%**	**81.3%**	**101.6%**
2	Brambling	34.7%	0.0%	**95.2%**	**112.4%**	**138.6%**	**133.4%**
1	Swift Ward	12.6%	0.0%	**93.0%**	**102.7%**	**96.8%**	**99.2%**
1	Westerdale North	9.1%	11.3%	**102.4%**	**107.8%**	**121.7%**	**157.8%**

- From the 54 level 3 self-harm incidents this equated to 18 wards across 5 localities.
- Durham & Darlington had the highest number of level 3 incidents in the reporting period with 20 incidents in total.
- Elm Ward had the highest number of level 3 incidents across the reporting period with 10 incidents.
- 5 out of 18 wards reported as ‘red’ for their bank usage whilst all the others reported either as ‘amber’ or ‘green’.
- 12 out of 19 wards reported as ‘red’ for their agency usage whilst all the others reported as either ‘amber’ or ‘green’.
- Birch, Lustrum Vale and Maple reported as ‘red’ for both their bank and agency usage.
- There were 8 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 Name	Bank Usage	Agency Usage	Staffing Fill Rate			
				RN Days	RN Nights	HCA Day	HCA Night
2	Bedale Ward	13.2%	12.0%	**89.9%**	**101.2%**	**137.4%**	**184.3%**
4	Bilsdale	11.6%	4.4%	**94.3%**	**100.6%**	**110.0%**	**110.4%**
1	Bransdale	10.5%	4.0%	**100.8%**	**102.7%**	**109.9%**	**107.9%**
1	Cedar	22.6%	2.2%	**102.6%**	**103.4%**	**102.1%**	**101.6%**

1	Cedar (NY)	7.0%	55.2%	**82.7%**	**138.3%**	**148.2%**	**108.7%**
4	Elm Ward	22.2%	5.1%	**102.4%**	**103.0%**	**93.3%**	**116.1%**
1	Farnham Ward	5.5%	2.9%	**92.5%**	**104.4%**	**153.7%**	**117.3%**
2	Maple	26.4%	6.9%	**89.3%**	**104.7%**	**131.3%**	**161.5%**
3	Overdale	7.8%	7.3%	**97.4%**	**102.3%**	**126.0%**	**127.9%**
1	Primrose Lodge	10.6%	0.0%	**88.0%**	**100.0%**	**106.0%**	**100.0%**
3	Newberry Centre	14.3%	7.3%	**101.1%**	**119.5%**	**133.1%**	**183.6%**
1	The Evergreen Centre	19.1%	15.8%	**80.1%**	**108.4%**	**133.6%**	**179.1%**
3	Westwood Centre	25.1%	1.9%	**74.0%**	**73.7%**	**81.3%**	**101.6%**
1	Harrier / Hawk	17.5%	0.1%	**94.2%**	**106.6%**	**96.4%**	**100.2%**
1	Lark	25.1%	0.0%	**99.6%**	**107.3%**	**105.3%**	**119.7%**
1	Mandarin	32.0%	0.0%	**103.5%**	**127.4%**	**145.4%**	**179.9%**
1	Merlin	25.8%	0.0%	**109.6%**	**103.7%**	**127.4%**	**161.7%**
2	Nightingale	11.4%	0.0%	**86.4%**	**106.1%**	**104.5%**	**100.3%**
1	Bek-Ramsey	13.0%	7.6%	**81.8%**	**108.7%**	**132.8%**	**136.3%**
2	Ceddesfeld	6.5%	3.4%	**99.3%**	**100.6%**	**118.7%**	**116.4%**
2	Oak Ward	8.7%	5.8%	**99.8%**	**100.0%**	**114.6%**	**124.3%**
1	Roseberry Wards	7.5%	0.0%	**100.7%**	**100.1%**	**100.0%**	**101.1%**
2	Rowan Ward	9.6%	36.8%	**102.6%**	**143.5%**	**177.0%**	**179.3%**

- None of the complaints raised cited issues with staffing levels or skill mix. However, there were 2 complaints that did raise concerns with regards to staff attitude (Nightingale and Mandarin).
- Teesside locality had the highest number of complaints in the reporting period with 17 complaints raised.
- From those that had complaints raised 5 wards reported as ‘red’ for bank usage whilst the remaining wards reported either as ‘amber’ or ‘green’
- From those wards that had complaints raised 12 wards reported as ‘red’ for their agency usage whilst the remaining wards reported as either ‘amber’ or ‘green’.
- Maple was the only ward that had complaints raised that reported as ‘red’ for both their bank and agency usage.
- 10 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	25.1%	1.9%	961	5	1706	1711
Evergreen Centre	19.1%	15.8%	878	10	1483	1493
Sandpiper Ward	23.5%	0.0%	192	15	501	516
Bek-Ramsey Ward	13.0%	7.6%	203	10	377	387
Oak Rise	12.3%	19.0%	245		295	295
Newberry Centre	14.3%	7.3%	177	3	248	251
Bedale Ward	13.2%	12.0%	131	9	202	211
Cedar	22.6%	2.2%	137	3	202	205
Bankfields Court	6.8%	0.0%	102		154	154
Brambling	34.7%	0.0%	78	1	136	137

- The Westwood Centre had 961 incidents requiring the use of restraint during the reporting period. This equated to 1,711 restraints of which 5 was recorded as 'Prone'.
- Westwood and Brambling were 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 Day	HCA Night
Westwood Centre	**74.0%**	**73.7%**	**81.3%**	**101.6%**
The Evergreen Centre	**80.1%**	**108.4%**	**133.6%**	**179.1%**
Sandpiper Ward	**100.7%**	**97.2%**	**102.6%**	**129.5%**
Bek-Ramsey Ward	**81.8%**	**108.7%**	**132.8%**	**136.3%**
Oak Rise	**107.7%**	**101.9%**	**127.6%**	**133.3%**
Newberry Centre	**101.1%**	**119.5%**	**133.1%**	**183.6%**
Bedale Ward	**89.9%**	**101.2%**	**137.4%**	**184.3%**
Cedar	**102.6%**	**103.4%**	**102.1%**	**101.6%**
Bankfields Court	**112.5%**	**183.5%**	**103.6%**	**104.1%**
Brambling	**95.2%**	**112.4%**	**138.6%**	**133.4%**

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 92 episodes of Prone used. This is a reduction of 43 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 and the Quality Data Team are developing 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
Overdale	Teesside	Adults	1
Acomb Garth	York and Selby	MHSOP	1
Cherry Tree House	York and Selby	MHSOP	1
Rowan Lea	North Yorkshire	MHSOP	1
Westerdale North	Teesside	MHSOP	1

- All but one of the falls 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:

    - Acomb Garth and Rowan Lea have a red fill rate for registered nurses on days. All other fill rate indicators are reporting as either 'green' or 'blue'.
    - Rowan Lea 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 Rowan Lea 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 10 incidents reported across 8 wards as follows:

Ward / Team	Locality	Speciality	Number of incidents
Baysdale	Teesside	CYPS	1
Mallard	Forensics	Forensics MH	1
Cherry Tree House	York and Selby	MHSOP	1
Oak Ward	Durham & Darlington	MHSOP	1
Roseberry Wards	Durham & Darlington	MHSOP	1
Rowan Lea	North Yorkshire	MHSOP	2
Rowan Ward	North Yorkshire	MHSOP	2
Westerdale North	Teesside	MHSOP	1

- The majority 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'.
  - Mallard and Rowan Lea reported as 'red' whilst the others reported as either 'amber' or 'green' for bank usage.
  - Baysdale, Mallard and Roseberry Ward all reported 'green' for their agency usage. All others reported as 'red'.
  - Baysdale and Cherry Tree 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 411 incidents of medication errors reported within the reporting period across all wards (68). The top 6 wards are shown as follows:

Ward / Team	Locality	Specialty	Number of incidents
Brambling	Forensics	Forensics MH	26
Mallard	Forensics	Forensics MH	18
Maple	Durham &Darlington	Adults	17
Willow Ward	Durham &Darlington	Adults	13
Evergreen Centre	Teesside	CYPS	13
Northdale Centre	Forensics	Forensics LD	13
Birch Ward	Durham &Darlington	Adults	12
Minster Ward	York and Selby	Adults	12
Westwood Centre	Teesside	CYPS	11
Cherry Tree House	York and Selby	MHSOP	11
Meadowfields	York and Selby	MHSOP	11
Oak Ward	Durham &Darlington	MHSOP	11

- There are 5 fill rate indicators reporting as 'red' for Maple, Evergreen and Westwood. All other fill rate indicators are reporting as either 'green' or 'blue'.
- Birch, Maple, Westwood, Northdale, Brambling and Mallard are all reporting as 'red' for their bank usage. All others are reporting as either 'amber' or 'green'.
- Birch, Maple, Minster, Evergreen, Cherry Tree, Meadowfields and Oak Ward are all reported as 'red' for their agency usage. All others are reporting as 'green'.
- Minster, Westwood and Cherry Tree are reporting as 'red' for their overtime usage. All others are reporting as either 'amber' or 'green'.

3.4.16 In terms of shifts worked without a break there were 1,951 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
Newberry	2,383	204	8.56%	132	72
Westwood	2,594	202	7.79%	175	27
Evergreen	3,463	190	5.49%	159	31
Cedar Ward (NY)	1,987	82	4.13%	75	7
Esk Ward	1,742	66	3.79%	34	32

- 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. An agreement has now been reached and will be reflected in the data in future reports.
- The absence of breaks is also 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	Staffing Fill Rate			
			RN Day	RN Night	HCA Day	HCA Night
Esk Ward	10.9%	7.2%	80.8%	102.0%	128.1%	110.7%
Cedar (NY)	7.0%	55.2%	82.7%	138.3%	148.2%	108.7%
Newberry Centre	14.3%	7.3%	101.1%	119.5%	133.1%	183.6%
Evergreen Centre	19.1%	15.8%	80.1%	108.4%	133.6%	179.1%
Westwood Centre	25.1%	1.9%	74.0%	73.7%	81.3%	101.6%

- There are 6 fill rate indicators' that are reporting as 'red' and the majority are in relation to registered nurses on days. All other indicators are reporting as either 'green' or 'blue'
- Westwood Centre is reporting as 'red' for bank usage. All other areas are reporting as either 'amber' or 'green'.

- All wards with the exception of Westwood Centre are reporting as 'red' for their agency usage.

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 148 incidents raised citing issues with staffing. This is an increase of 19 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	40	↑ (32)
Durham & Darlington	32	↑ (13)
Teesside	42	↑ (36)
Forensics	15	↓ (22)
York and Selby	19	↓ (26)

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

- 148 incidents were reported citing staffing levels as the reason, 26 night shifts 122 day shifts.

Key themes:

- 82% (122) incidents citing staffing levels were for day duty

- Enhanced observations increasing staffing requirements
- Agency staff failed to attend for duty
- Wards not running on required staffing levels/ mix
- Staff sickness and short notice sickness
- Staff being moved from ward to ward
- High acuity
- Imbalance of agency/bank staff to permanent staff

Issues reported:

- Breaks not being taken
- Staff and patient safety compromised
- Wards not running on required staffing levels
- Patient leave and activities being cancelled
- Unable to respond to alarms from other wards in difficulty
- 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.
- Dangerously low staffing levels
- Safety checks not carried out

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) escalation process is now operational following approval at EMT and the successful pilots in Durham and Darlington and North Yorkshire and York localities.

Further discussion to take place at the Right Staffing Establishment workstream regarding the potential blocks that may contribute to under reporting via the Datix system.

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, 2 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? 163 comments were received that suggested improved staffing was required within our inpatient wards trust wide to support further activities including supporting leave and continuity of care.

3.6.4 The trust receives compliments and these are captured and published via the weekly e-Bulletin. A total of 331compliments 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 10.5 (3.7 registered nurses; 6.7 healthcare assistants; 0 registered AHP and 0 unregistered AHP). This can be broken down by locality as follows:

Locality	Care Hours per Patient Day					Trend on Previous 6 Months
	RN	HCA	Reg AHP	Un-reg AHP	Overall	
Durham & Darlington	3.5	5.5	0.1	0.1	9.3	↓ (10.6)
Forensics	3.6	6.8	0.0	0.0	10.4	↓ (13.8)
North Yorkshire	3.9	6.5	0.2	0.0	10.6	↑ (9.8)
Teesside	3.9	7.4	0.1	0.0	11.3	↓ (15.8)
York & Selby	4.1	7.8	0.3	0.1	12.3	↓ (12.4)

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

Speciality	RN	HCA	Reg AHP	Un-reg AHP	Overall	Trend on Previous 6 Months
Acute	2.8	4.0	0.2	0.1	7.0	↑ (6.7)
Adult LD	6.5	16.1	0.1	0.0	22.7	↑ (21.7)
Child LD	8.2	14.0	0.0	0.0	22.2	↑ (21.1)
Eating Disorders	3.8	5.9			9.7	↑ (8.7)
Forensic LD	4.2	8.8	0.0	0.0	13.0	↓ (13.4)
High Dependency Rehab	3.6	5.0	0.4	0.4	9.5	↑ (8.0)
Locked Rehab	2.9	5.5			8.4	↓ (8.9)
Long Term Complex Continuing Care	3.4	4.8	0.3	0.1	8.6	↑ (7.3)
Low Secure	3.2	5.5	0.0	0.0	8.7	↑ (8.3)
Medium Secure	3.6	6.2	0.0	0.0	9.8	↑ (9.3)
Older Adults Acute	3.6	7.1	0.1	0.0	10.8	↑ (9.5)
Other Specialist MH Beds	5.1	11.7			16.8	↑ (16.5)
PICU	8.1	11.3	0.0	0.0	19.4	↓ (19.5)
TIER 4	5.6	11.2	0.0	0.0	16.8	↓ (17.3)

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 reports.

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 however it does highlight potential quality of care issues related to the skill mix on day shifts due to defecits of registered nursing staff and high levels of bank/agency use in some ward areas. Systems are in place for escalation and operational management of staffing levels on a daily basis. There is 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, inititaives such as central and over-recruitment across operational services and an increase in the Temporary Staffing Service infrastructure and recruitment of bank nurses have been put in place to reduce agency usage and improve continuity and therefore quality of care.

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 Extensive analysis of the available data in this report would suggest quality issues related to high bank or agency usage in some ward areas and the ability to meet planned staffing levels for registered nurses on day shifts.

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 – June 2019
Ann Marshall, 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 30/11/2018				Establishment at 31/05/2019				Comparison to 30/11/2018 to 31/05/2019 Budget v Actual WTE hours			
			Registered staff		Unregistered staff		Registered		Unregistered		Registered Staff		Unregistered Staff	
			Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
D&D	Cedar Ward	Adults	14.30	14.80	14.30	14.20	14.30	13.80	15.30	13.40	0.00	-1.00	1.00	-0.80
D&D	Birch Ward	Adults	12.30	12.70	14.30	10.60	14.67	14.70	14.30	9.30	2.37	2.00	0.00	-1.30
D&D	Primrose Lodge	Adults	8.58	7.00	8.58	11.00	8.58	7.80	11.44	11.00	0.00	0.80	2.86	0.00
D&D	Willow Ward	Adults	8.58	8.60	8.58	10.60	8.58	9.30	11.44	10.90	0.00	0.70	2.86	0.30
D&D	Maple Ward	Adults	11.44	11.80	11.44	11.20	11.44	11.00	11.44	11.20	0.00	-0.80	0.00	0.00
D&D	Elm Ward	Adults	11.44	8.70	11.44	9.80	11.44	8.70	11.44	8.60	0.00	0.00	0.00	-1.20
D&D	Farnham Ward	Adults	11.44	9.70	11.44	12.70	11.44	10.60	11.44	13.50	0.00	0.90	0.00	0.80
D&D	Tunstall Ward	Adults	11.44	12.40	11.44	11.10	11.44	11.40	11.44	10.60	0.00	-1.00	0.00	-0.50
D&D	Holly Unit	CYPS	5.60	3.70	5.60	5.60	4.32	4.60	5.47	4.90	-1.28	0.90	-0.13	-0.70
D&D	Bek, Ramsey	LD	8.60	7.60	20.02	21.00	8.58	8.90	20.02	21.80	-0.02	1.30	0.00	0.80
D&D	Ceddesfeld Ward	MHSOP	8.58	8.80	13.23	15.70	8.58	7.80	13.23	15.70	0.00	-1.00	0.00	0.00
D&D	Hamsterley Ward	MHSOP	8.58	9.40	13.23	17.50	8.58	9.00	13.23	23.70	0.00	-0.40	0.00	6.20
D&D	Oak Ward	MHSOP	8.58	8.90	11.44	12.60	8.58	8.90	11.44	12.60	0.00	0.00	0.00	0.00
D&D	Roseberry Wards	MHSOP	8.58	8.60	10.52	11.90	8.58	8.60	10.52	11.50	0.00	0.00	0.00	-0.40
Forensics	Clover/Ivy	FLD	8.10	9.70	20.20	15.50	8.10	8.70	20.20	16.40	0.00	-1.00	0.00	0.90
Forensics	Thistle Ward	FLD	8.50	8.00	15.30	13.40	8.50	6.00	14.84	14.10	0.00	-2.00	-0.46	0.70
Forensics	Northdale Centre	FLD	8.10	8.60	26.80	24.40	8.05	10.00	26.82	24.40	-0.05	1.40	0.02	0.00
Forensics	Oakwood	FLD	8.10	7.10	6.60	8.00	8.05	8.40	14.85	7.00	-0.05	1.30	8.25	-1.00
Forensics	Harrier/Hawk	FLD	8.10	9.70	20.20	19.10	8.08	8.00	20.20	20.00	-0.02	-1.70	0.00	0.90
Forensics	Langley Ward	FLD	8.40	6.90	9.30	7.00	8.05	7.00	6.35	7.00	-0.35	0.10	-2.95	0.00
Forensics	Kestrel/Kite	FLD	8.10	9.70	22.10	21.20	8.05	9.70	22.05	19.60	-0.05	0.00	-0.05	-1.60

Forensics	Brambling Ward	FMH	8.10	7.80	13.70	10.90	8.05	8.90	13.65	12.80	-0.05	1.10	-0.05	1.90
Forensics	Jay Ward	FMH	8.10	8.50	13.20	13.40	8.05	7.90	13.15	12.40	-0.05	-0.60	-0.05	-1.00
Forensics	Sandpiper Ward	FMH	10.70	13.80	17.60	14.90	10.73	12.50	17.61	15.50	0.03	-1.30	0.01	0.60
Forensics	Merlin	FMH	10.70	10.40	15.30	15.20	10.73	10.40	15.32	14.20	0.03	0.00	0.02	-1.00
Forensics	Swift Ward	FMH	8.10	6.60	15.80	15.40	8.05	8.60	15.32	15.30	-0.05	2.00	-0.48	-0.10
Forensics	Lark	FMH	8.10	8.00	13.70	12.90	8.05	7.50	13.15	11.90	-0.05	-0.50	-0.55	-1.00
Forensics	Kirkdale Ward	FMH	8.10	6.90	15.30	12.80	8.05	7.90	15.32	13.80	-0.05	1.00	0.02	1.00
Forensics	Mallard Ward	FMH	8.10	9.00	15.30	14.50	8.05	8.20	15.32	15.30	-0.05	-0.80	0.02	0.80
Forensics	Mandarin	FMH	8.10	10.50	13.20	11.30	8.05	11.70	13.15	11.70	-0.05	1.20	-0.05	0.40
Forensics	Nightingale Ward	FMH	8.10	7.50	13.20	14.10	8.05	9.70	13.15	15.10	-0.05	2.20	-0.05	1.00
Forensics	Linnet Ward	FMH	8.10	9.30	13.20	12.80	8.05	7.90	13.15	12.80	-0.05	-1.40	-0.05	0.00
Forensics	Newtondale Ward	FMH	10.80	10.00	18.90	15.40	10.73	10.90	17.88	19.20	-0.07	0.90	-1.02	3.80
North Yorkshire	The Orchards	Adults	8.80	9.50	8.10	5.70	8.80	8.60	8.10	8.10	0.00	-0.90	0.00	2.40
North Yorkshire	Ayckbourn Unit Danby Ward	Adults	9.50	10.00	10.70	8.00	9.50	10.00	10.70	12.00	0.00	0.00	0.00	4.00
North Yorkshire	Ayckbourn Unit Esk Ward	Adults	10.60	5.40	10.70	9.80	9.60	6.40	10.70	11.80	-1.00	1.00	0.00	2.00
North Yorkshire	Cedar Ward (NY)	Adults	10.10	4.10	15.20	6.00	10.10	4.40	13.40	11.60	0.00	0.30	-1.80	5.60
North Yorkshire	Rowan Ward	MHSOP	9.10	7.60	10.70	11.50	9.10	8.60	10.70	11.10	0.00	1.00	0.00	-0.40
North Yorkshire	Springwood Community Unit	MHSOP	8.10	7.00	12.50	12.40	8.10	7.80	12.50	12.40	0.00	0.80	0.00	0.00
North Yorkshire	Rowan Lea	MHSOP	9.60	9.60	17.90	15.90	8.60	7.60	17.90	18.30	-1.00	-2.00	0.00	2.40
York & Selby	Ebor Ward	Adults	8.70	8.60	11.00	10.00	8.70	6.70	11.00	10.00	0.00	-1.90	0.00	0.00
York & Selby	Minster Ward	Adults	8.20	7.90	9.00	9.80	8.20	7.50	11.00	10.80	0.00	-0.40	2.00	1.00
York & Selby	Cherry Tree House	MHSOP	8.90	11.40	13.70	11.20	8.90	11.70	13.70	11.40	0.00	0.30	0.00	0.20
York & Selby	Oak Rise	ALD	8.20	7.60	18.80	12.80	8.20	7.50	18.80	14.50	0.00	-0.10	0.00	1.70
York & Selby	Acomb Garth	MHSOP	11.40	9.10	13.70	14.30	11.40	7.20	16.50	12.40	0.00	-1.90	2.80	-1.90
York & Selby	Meadowfields	MHSOP	8.20	7.80	16.70	10.60	8.20	4.50	13.70	10.70	0.00	-3.30	-3.00	0.10
Teesside	Bedale Ward	Adults	13.70	12.00	13.70	13.70	13.70	14.00	13.70	12.90	0.00	2.00	0.00	-0.80
Teesside	Bilsdale Ward	Adults	8.20	7.80	11.00	11.70	8.20	8.80	11.00	11.70	0.00	1.00	0.00	0.00

Teesside	Bransdale Ward	Adults	8.20	9.00	11.00	12.70	8.20	9.00	11.00	11.10	0.00	0.00	0.00	-1.60
Teesside	Overdale Ward	Adults	8.20	7.60	11.00	10.50	8.20	8.60	11.00	10.50	0.00	1.00	0.00	0.00
Teesside	Stockdale Ward	Adults	8.20	7.40	11.00	10.50	8.20	9.40	11.00	9.00	0.00	2.00	0.00	-1.50
Teesside	Lustrum Vale	Adults	11.10	11.30	11.00	10.50	11.10	9.30	11.00	10.50	0.00	-2.00	0.00	0.00
Teesside	Baysdale	CYPS	6.70	6.00	12.70	13.30	6.70	8.00	12.70	13.50	0.00	2.00	0.00	0.20
Teesside	Newberry Centre	CYPS	15.00	18.70	15.20	19.20	15.00	15.30	15.20	18.00	0.00	-3.40	0.00	-1.20
Teesside	The Evergreen Centre	CYPS	16.20	19.20	18.70	15.40	16.20	14.80	18.70	19.60	0.00	-4.40	0.00	4.20
Teesside	Westwood Centre	CYPS	17.10	17.00	16.50	24.80	17.10	17.10	16.50	23.90	0.00	0.10	0.00	-0.90
Teesside	Thornaby Road	LD	11.40	12.40	11.40	11.10	3.60	3.80	11.90	9.70	-7.80	-8.60	0.50	-1.40
Teesside	Aysgarth	LD	6.00	6.40	11.50	8.60	6.50	6.50	11.50	9.30	0.50	0.10	0.00	0.70
Teesside	Bankfields Court Flats	LD	14.30	15.20	58.30	39.30	10.40	17.90	42.70	43.30	-3.90	2.70	-15.60	4.00
Teesside	Bankfields Court Unit 2	LD	7.60	7.50	9.50	8.90	5.40	8.20	10.70	8.30	-2.20	0.70	1.20	-0.60
Teesside	The Lodge	LD	11.40	4.60	11.40	5.00	2.50	0.00	2.50	0.00	-8.90	-4.60	-8.90	-5.00
Teesside	Westerdale South	MHSOP	10.80	14.40	12.20	19.60	14.40	12.70	14.50	16.80	3.60	-1.70	2.30	-2.80
Teesside	Westerdale North	MHSOP	10.60	14.10	11.10	12.90	11.60	13.10	11.80	12.30	1.00	-1.00	0.70	-0.60
		Trust Totals	604.64	596.60	890.36	833.40	585.03	580.00	879.73	852.70	**-19.61**	**-16.90**	**-10.63**	**19.30**

Average fill rate covering the period of 1st December 2018 to 31st May 2019

Appendix 2

Ward Name	Locality	Speciality	Bed Numbers (MAY)	6 Months - 1st December 2018 to 31st May 2019							
				Nursing Average %		Health Care Average %		Bank Usage vs Actual Hours		Agency Usage vs Actual Hours	
				Day	Night	Day	Night	Hours	% against Actual Hours	Hours	% against Actual Hours
Bek-Ramsey Ward	Durham and Darlington	LD	6	81.8%	108.7%	132.8%	136.3%	3531.17	13.0%	2055.5	7.6%
Birch Ward	Durham and Darlington	Adults	15	91.3%	101.1%	140.8%	141.6%	6510.61	31.0%	1245.3	5.9%
Cedar	Durham and Darlington	Adults	10	102.6%	103.4%	102.1%	101.6%	5840.20	22.6%	575.7	2.2%
Ceddesfeld	Durham and Darlington	MHSOP	15	99.3%	100.6%	118.7%	116.4%	1283.83	6.5%	672.0	3.4%
Elm Ward	Durham and Darlington	Adults	20	102.4%	103.0%	93.3%	116.1%	4174.21	22.2%	966.2	5.1%
Farnham Ward	Durham and Darlington	Adults	20	92.5%	104.4%	153.7%	117.3%	1122.51	5.5%	600.0	2.9%
Hamsterley	Durham and Darlington	MHSOP	15	104.0%	100.5%	174.2%	179.4%	3479.51	13.7%	1853.7	7.3%
Holly	Durham and Darlington	CYPS	4	246.7%	160.9%	276.3%	274.7%	2180.10	21.1%	53.0	0.5%
Maple	Durham and Darlington	Adults	20	89.3%	104.7%	131.3%	161.5%	5435.35	26.4%	1415.6	6.9%
Oak Ward	Durham and Darlington	MHSOP	12	99.8%	100.0%	114.6%	124.3%	1590.66	8.7%	1054.1	5.8%
Primrose Lodge	Durham and Darlington	Adults	15	88.0%	100.0%	106.0%	100.0%	1674.83	10.6%	0.0	0.0%
Roseberry Wards	Durham and Darlington	MHSOP	15	100.7%	100.1%	100.0%	101.1%	1183.91	7.5%	0.0	0.0%
Tunstall Ward	Durham and Darlington	Adults	20	111.7%	103.3%	119.1%	117.9%	1320.00	6.8%	576.0	3.0%
Willow Ward	Durham and Darlington	Adults	15	111.3%	101.4%	128.0%	105.1%	2974.75	17.2%	240.0	1.4%
Brambling	Forensics	Forensics MH	14	95.2%	112.4%	138.6%	133.4%	7151.00	34.7%	0.0	0.0%
Clover / Ivy	Forensics	Forensics LD	10	111.4%	105.8%	86.2%	137.0%	6631.30	29.9%	11.3	0.1%
Harrier / Hawk	Forensics	Forensics LD	10	94.2%	106.6%	96.4%	100.2%	3796.41	17.5%	11.3	0.1%
Jay Ward	Forensics	Forensics MH	5	86.4%	103.6%	96.1%	94.9%	1181.25	7.4%	0.0	0.0%
Kestrel / Kite.	Forensics	Forensics LD	16	95.2%	106.5%	115.9%	145.2%	8665.09	32.9%	578.5	2.2%
Langley	Forensics	Forensics LD	5	73.4%	100.0%	94.0%	100.0%	1272.42	10.9%	90.0	0.8%
Lark	Forensics	Forensics MH	17	99.6%	107.3%	105.3%	119.7%	4591.92	25.1%	0.0	0.0%
Linnet Ward	Forensics	Forensics MH	17	93.1%	104.4%	130.8%	133.9%	3677.59	18.3%	0.0	0.0%
Mallard	Forensics	Forensics MH	14	100.3%	118.8%	135.2%	166.2%	6526.97	26.8%	0.0	0.0%
Mandarin	Forensics	Forensics MH	16	103.5%	127.4%	145.4%	179.9%	7592.23	32.0%	0.0	0.0%
Merlin	Forensics	Forensics MH	10	109.6%	103.7%	127.4%	161.7%	6654.83	25.8%	0.0	0.0%
Newtondale	Forensics	Forensics MH	20	106.2%	92.9%	98.7%	112.6%	2554.98	11.0%	0.0	0.0%
Nightingale	Forensics	Forensics MH	16	86.4%	106.1%	104.5%	100.3%	1918.65	11.4%	0.0	0.0%

Northdale Centre	Forensics	Forensics LD	12	98.3%	112.9%	103.0%	120.7%	9657.12	32.4%	22.5	0.1%
Oakwood	Forensics	Forensics LD	8	83.3%	100.7%	220.8%	106.7%	1932.62	14.8%	0.0	0.0%
Sandpiper Ward	Forensics	Forensics MH	7	100.7%	97.2%	102.6%	129.5%	5656.50	23.5%	0.0	0.0%
Swift Ward	Forensics	Forensics MH	10	93.0%	102.7%	96.8%	99.2%	2293.00	12.6%	0.0	0.0%
Thistle	Forensics	Forensics LD	5	81.0%	104.0%	109.0%	103.1%	2816.51	15.5%	0.0	0.0%
Ayckbourn Danby Ward	North Yorkshire	Adults	12	106.1%	100.8%	125.6%	102.7%	2883.50	16.4%	576.0	3.3%
Ayckbourn Esk Ward	North Yorkshire	Adults	12	80.8%	102.0%	128.1%	110.7%	1745.25	10.9%	1153.0	7.2%
Cedar (NY)	North Yorkshire	Adults	14	82.7%	138.3%	148.2%	108.7%	1394.37	7.0%	11003.1	55.2%
Rowan Lea	North Yorkshire	MHSOP	20	89.1%	100.4%	157.5%	141.9%	6841.04	25.2%	4400.6	16.2%
Rowan Ward	North Yorkshire	MHSOP	16	102.6%	143.5%	177.0%	179.3%	2270.50	9.6%	8754.9	36.8%
Springwood	North Yorkshire	MHSOP	14	91.3%	100.4%	126.0%	204.5%	2874.22	13.1%	3391.0	15.4%
The Orchards (NY)	North Yorkshire	Adults	10	81.8%	84.9%	105.5%	86.2%	940.00	7.6%	252.0	2.0%
Ward 14	North Yorkshire	MHSOP	10	92.7%	93.5%	114.6%	105.2%	928.75	13.9%	456.8	6.8%
Ward 15	North Yorkshire	Adults	12	77.4%	100.1%	149.8%	134.4%	1853.75	21.3%	1637.8	18.8%
Aysgarth	Teesside	LD	6	122.9%	107.3%	96.9%	104.5%	2321.20	20.1%	0.0	0.0%
Bankfields Court	Teesside	LD	18	112.5%	183.5%	103.6%	104.1%	3027.17	6.8%	0.0	0.0%
Bankfields Court Unit 2	Teesside	LD	5	113.9%	104.5%	91.5%	103.0%	1686.11	15.7%	0.0	0.0%
Baysdale	Teesside	CYPS	6	124.6%	108.0%	111.5%	106.6%	1623.04	10.3%	0.0	0.0%
Bedale Ward	Teesside	Adults	10	89.9%	101.2%	137.4%	184.3%	3542.00	13.2%	3234.7	12.0%
Bilsdale	Teesside	Adults	18	94.3%	100.6%	110.0%	110.4%	1831.30	11.6%	696.5	4.4%
Bransdale	Teesside	Adults	14	100.8%	102.7%	109.9%	107.9%	1668.05	10.5%	644.0	4.0%
Kirkdale	Teesside	Adults	16	94.3%	100.0%	95.2%	128.1%	4596.00	24.2%	573.8	3.0%
Lustrum Vale	Teesside	Adults	20	94.4%	101.8%	187.4%	175.1%	7590.50	33.3%	1435.5	6.3%
Newberry Centre	Teesside	CYPS	14	101.1%	119.5%	133.1%	183.6%	3539.36	14.3%	1813.1	7.3%
Overdale	Teesside	Adults	14	97.4%	102.3%	126.0%	127.9%	1341.00	7.8%	1251.5	7.3%
Stockdale	Teesside	Adults	18	99.3%	100.8%	110.8%	115.3%	2729.98	17.2%	910.5	5.7%
The Evergreen Centre	Teesside	CYPS	16	80.1%	108.4%	133.6%	179.1%	6181.17	19.1%	5110.2	15.8%
The Lodge	Teesside	LD	1	36.4%	25.8%	31.9%	56.0%	168.00	4.2%	0.0	0.0%
Westerdale North	Teesside	MHSOP	20	102.4%	107.8%	121.7%	157.8%	1948.00	9.1%	2416.3	11.3%
Westerdale South	Teesside	MHSOP	14	108.7%	79.6%	170.3%	315.2%	9384.87	30.6%	3658.5	11.9%
Westwood Centre	Teesside	CYPS	12	74.0%	73.7%	81.3%	101.6%	6555.00	25.1%	504.3	1.9%
Acomb Garth	York and Selby	MHSOP	10	78.6%	95.7%	124.1%	190.3%	1808.75	6.4%	12011.3	42.3%
Cherry Tree House	York and Selby	MHSOP	18	100.4%	105.5%	112.8%	148.2%	2174.17	10.6%	4003.3	19.5%
Ebor Ward	York and Selby	Adults	12	94.5%	98.9%	84.2%	104.2%	1628.50	9.8%	2053.0	12.4%

Meadowfields	York and Selby	MHSOP	8	**91.6%**	**99.5%**	**119.0%**	**154.1%**	4336.83	21.0%	6698.0	32.4%
Minster Ward	York and Selby	Adults	12	**99.7%**	**99.2%**	**99.2%**	**108.4%**	961.50	5.7%	2068.5	12.2%
Oak Rise	York and Selby	LD	8	**107.7%**	**101.9%**	**127.6%**	**133.3%**	3358.72	12.3%	5211.0	19.0%
Harland Rehab Ward	Durham and Darlington	Rehab	1	**94.1%**	**84.3%**	**36.3%**	**42.2%**	376.00	18.3%	0.0	0.0%
Kiltonview	Teesside	Day Unit	0	**94.8%**		**88.2%**		1514.24	14.4%	0.0	0.0%
The Orchard	Teesside	Day Unit	0	**85.1%**		**81.0%**		797.84	13.7%	0.0	0.0%
Thornaby Road	Teesside	Day Unit	5	**101.0%**		**114.0%**	**101.7%**	680.80	6.0%	0.0	0.0%

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	Overtime (inc AHPs)		Agency (Nursing)		Bank (Nursing)		Maternity (inc APHs)		Sickness (inc AHPs)		Vacancies (inc AHPs)	
			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
Ayckbourn Danby Ward	North Yorkshire	Adults	739.58	3.9%	576.0	3.3%	2883.5	16.4%	975.0	5.1%	689.2	3.6%	510.0	2.7%
Ayckbourn Esk Ward	North Yorkshire	Adults	107.83	0.6%	1153.0	7.2%	1745.3	10.9%	2070.0	11.7%	168.0	0.9%	1503.8	8.5%
Bedale Ward	Teesside	Adults	949.68	3.5%	3234.7	12.0%	3542.0	13.2%	262.5	1.0%	883.5	3.3%	738.8	2.7%
Bilsdale	Teesside	Adults	503.33	3.2%	696.5	4.4%	1831.3	11.6%	1312.5	8.3%	1944.4	12.3%	588.8	3.7%
Birch Ward	Durham & Darlington	Adults	245.87	1.1%	1245.3	5.9%	6510.6	31.0%	607.5	2.7%	1725.0	7.5%	1365.0	6.0%
Bransdale	Teesside	Adults	217.5	1.4%	644.0	4.0%	1668.1	10.5%	161.3	1.0%	1216.5	7.6%	896.3	5.6%
Cedar	Durham & Darlington	Adults	474.83	1.8%	575.7	2.2%	5840.2	22.6%	0.0	0.0%	2705.5	10.5%	1170.0	4.5%
Cedar (NY)	North Yorkshire	Adults	269.75	1.3%	11003.1	55.2%	1394.4	7.0%	0.0	0.0%	263.3	1.3%	2673.8	13.0%
Ebor Ward	York and Selby	Adults	292	1.5%	2053.0	12.4%	1628.5	9.8%	0.0	0.0%	34.5	0.2%	1350.0	7.1%
Elm Ward	Durham & Darlington	Adults	422	2.2%	966.2	5.1%	4174.2	22.2%	675.0	3.5%	246.0	1.3%	1946.3	10.2%
Farnham Ward	Durham & Darlington	Adults	137.84	0.6%	600.0	2.9%	1122.5	5.5%	0.0	0.0%	691.3	3.2%	798.8	3.8%
Kirkdale	Teesside	Adults	804.95	3.9%	573.8	3.0%	4596.0	24.2%	765.0	3.7%	659.8	3.2%	948.8	4.5%
Lustrum Vale	Teesside	Adults	403.5	1.7%	1435.5	6.3%	7590.5	33.3%	851.0	3.5%	1638.5	6.7%	1068.8	4.4%
Maple	Durham & Darlington	Adults	324.35	1.5%	1415.6	6.9%	5435.4	26.4%	975.0	4.5%	3009.7	14.0%	513.8	2.4%
Minster Ward	York and Selby	Adults	848.5	4.7%	2068.5	12.2%	961.5	5.7%	23.0	0.1%	1495.5	8.3%	401.3	2.2%
Overdale	Teesside	Adults	560.3	3.3%	1251.5	7.3%	1341.0	7.8%	180.0	1.0%	806.0	4.7%	543.8	3.2%
Primrose Lodge	Durham & Darlington	Adults	108	0.6%	0.0	0.0%	1674.8	10.6%	0.0	0.0%	388.0	2.3%	547.5	3.2%
Stockdale	Teesside	Adults	376.43	2.4%	910.5	5.7%	2730.0	17.2%	391.0	2.5%	2337.5	14.7%	723.8	4.5%
The Orchards (NY)	North Yorkshire	Adults	358.5	2.7%	252.0	2.0%	940.0	7.6%	168.8	1.2%	723.0	5.3%	870.0	6.4%
Tunstall Ward	Durham & Darlington	Adults	384.84	1.8%	576.0	3.0%	1320.0	6.8%	1777.5	8.3%	1349.0	6.3%	536.3	2.5%
Ward 15	North Yorkshire	Adults	103.75	1.2%	1637.8	18.8%	1853.8	21.3%	0.0	0.0%	865.1	9.6%	746.3	8.3%
Willow Ward	Durham & Darlington	Adults	340	1.8%	240.0	1.4%	2974.8	17.2%	0.0	0.0%	1323.0	7.0%	300.0	1.6%
Baysdale	Teesside	CYPS	726.79	4.6%	0.0	0.0%	1623.0	10.3%	0.0	0.0%	837.3	5.3%	165.0	1.0%

Holly	Durham & Darlington	CYPS	1742.55	16.9%	53.0	0.5%	2180.1	21.1%	120.0	1.2%	266.3	2.6%	277.5	2.7%
Newberry Centre	Teesside	CYPS	1851.25	7.5%	1813.1	7.3%	3539.4	14.3%	2394.3	9.7%	2034.5	8.2%	1556.3	6.3%
The Evergreen Centre	Teesside	CYPS	910.09	2.6%	5110.2	15.8%	6181.2	19.1%	1710.5	4.9%	3490.7	10.0%	948.8	2.7%
Westwood Centre	Teesside	CYPS	1220.73	4.6%	504.3	1.9%	6555.0	25.1%	1360.5	5.1%	2853.3	10.7%	727.5	2.7%
Clover / Ivy	Forensics	Forensics LD	273.25	1.2%	11.3	0.1%	6631.3	29.9%	937.5	4.2%	1638.5	7.4%	2122.5	9.6%
Harrier / Hawk	Forensics	Forensics LD	873.66	4.0%	11.3	0.1%	3796.4	17.5%	825.0	3.8%	3688.5	17.0%	2103.8	9.7%
Kestrel / Kite.	Forensics	Forensics LD	448.65	1.7%	578.5	2.2%	8665.1	32.9%	1473.8	5.6%	3655.4	13.9%	1132.5	4.3%
Langley	Forensics	Forensics LD	95.25	0.8%	90.0	0.8%	1272.4	10.9%	0.0	0.0%	516.5	4.4%	1387.5	11.9%
Northdale Centre	Forensics	Forensics LD	999.42	3.4%	22.5	0.1%	9657.1	32.4%	881.3	3.0%	5002.3	16.8%	1848.8	6.2%
Oakwood	Forensics	Forensics LD	601.73	4.6%	0.0	0.0%	1932.6	14.8%	0.0	0.0%	471.3	3.6%	307.5	2.3%
Thistle	Forensics	Forensics LD	208.75	1.1%	0.0	0.0%	2816.5	15.5%	0.0	0.0%	205.8	1.1%	952.5	5.2%
Brambling	Forensics	Forensics MH	281.38	1.4%	0.0	0.0%	7151.0	34.7%	937.5	4.5%	1790.5	8.7%	427.5	2.1%
Jay Ward	Forensics	Forensics MH	494.73	3.1%	0.0	0.0%	1181.3	7.4%	0.0	0.0%	1044.8	6.5%	416.3	2.6%
Lark	Forensics	Forensics MH	484.75	2.7%	0.0	0.0%	4591.9	25.1%	1488.8	8.2%	1539.0	8.4%	851.3	4.7%
Linnet Ward	Forensics	Forensics MH	550.25	2.7%	0.0	0.0%	3677.6	18.3%	1207.5	6.0%	401.8	2.0%	611.3	3.0%
Mallard	Forensics	Forensics MH	557.25	2.3%	0.0	0.0%	6527.0	26.8%	0.0	0.0%	661.5	2.7%	708.8	2.9%
Mandarin	Forensics	Forensics MH	409.25	1.7%	0.0	0.0%	7592.2	32.0%	11.3	0.0%	877.5	3.7%	1061.3	4.5%
Merlin	Forensics	Forensics MH	777.19	3.0%	0.0	0.0%	6654.8	25.8%	22.5	0.1%	1485.0	5.8%	1170.0	4.5%
Newtondale	Forensics	Forensics MH	676.75	2.9%	0.0	0.0%	2555.0	11.0%	890.5	3.8%	723.8	3.1%	453.8	2.0%
Nightingale	Forensics	Forensics MH	397.65	2.4%	0.0	0.0%	1918.7	11.4%	0.0	0.0%	2086.1	12.4%	1005.0	6.0%
Sandpiper Ward	Forensics	Forensics MH	561.05	2.3%	0.0	0.0%	5656.5	23.5%	1252.5	5.2%	3680.0	15.3%	776.3	3.2%
Swift Ward	Forensics	Forensics MH	748.58	4.1%	0.0	0.0%	2293.0	12.6%	461.3	2.5%	1397.8	7.7%	585.0	3.2%
Aysgarth	Teesside	LD	443.1	3.8%	0.0	0.0%	2321.2	20.1%	315.0	2.7%	721.0	6.3%	581.3	5.0%
Bankfields Court	Teesside	LD	2375.45	5.3%	0.0	0.0%	3027.2	6.8%	2503.5	5.6%	2326.5	5.2%	3626.3	8.1%

Bankfields Court Unit 2	Teesside	LD	614.58	5.7%	0.0	0.0%	1686.1	15.7%	0.0	0.0%	927.2	8.6%	948.8	8.8%
Bek-Ramsey Ward	Durham & Darlington	LD	1908.74	7.0%	2055.5	7.6%	3531.2	13.0%	862.5	3.2%	5177.3	19.0%	603.8	2.2%
Oak Rise	York and Selby	LD	1314.09	4.7%	5211.0	19.0%	3358.7	12.3%	0.0	0.0%	397.0	1.4%	1192.5	4.3%
The Lodge	Teesside	LD	74.84	1.9%	0.0	0.0%	168.0	4.2%	1350.0	34.0%	0.0	0.0%	4016.3	101.0%
Acomb Garth	York and Selby	MHSOP	154	0.5%	12011.3	42.3%	1808.8	6.4%	0.0	0.0%	1605.4	5.5%	2205.0	7.6%
Ceddesfeld	Durham & Darlington	MHSOP	444.67	2.2%	672.0	3.4%	1283.8	6.5%	0.0	0.0%	1498.5	7.6%	333.8	1.7%
Cherry Tree House	York and Selby	MHSOP	932.88	4.2%	4003.3	19.5%	2174.2	10.6%	975.0	4.3%	749.0	3.3%	1248.8	5.6%
Hamsterley	Durham & Darlington	MHSOP	264.01	1.0%	1853.7	7.3%	3479.5	13.7%	0.0	0.0%	1694.7	6.5%	93.8	0.4%
Meadowfields	York and Selby	MHSOP	417	1.9%	6698.0	32.4%	4336.8	21.0%	450.0	2.1%	3135.3	14.6%	2216.3	10.3%
Oak Ward	Durham & Darlington	MHSOP	294.01	1.6%	1054.1	5.8%	1590.7	8.7%	0.0	0.0%	985.0	5.4%	472.5	2.6%
Roseberry Wards	Durham & Darlington	MHSOP	18.5	0.1%	0.0	0.0%	1183.9	7.5%	0.0	0.0%	504.0	3.2%	693.8	4.4%
Rowan Lea	North Yorkshire	MHSOP	733.82	2.6%	4400.6	16.2%	6841.0	25.2%	1312.0	4.7%	655.2	2.3%	412.5	1.5%
Rowan Ward	North Yorkshire	MHSOP	276	1.1%	8754.9	36.8%	2270.5	9.6%	1155.0	4.6%	631.7	2.5%	828.8	3.3%
Springwood	North Yorkshire	MHSOP	676.66	2.9%	3391.0	15.4%	2874.2	13.1%	0.0	0.0%	144.0	0.6%	611.3	2.6%
Ward 14	North Yorkshire	MHSOP	260.08	3.5%	456.8	6.8%	928.8	13.9%	0.0	0.0%	306.0	4.1%	708.8	9.6%
Westerdale North	Teesside	MHSOP	383.75	1.7%	2416.3	11.3%	1948.0	9.1%	0.0	0.0%	2220.0	9.7%	1481.3	6.5%
Westerdale South	Teesside	MHSOP	270.42	0.9%	3658.5	11.9%	9384.9	30.6%	2252.0	7.2%	1499.5	4.8%	1496.3	4.8%
Harland Rehab Ward	Durham & Darlington	Rehab	89.33	4.4%	0.0	0.0%	376.0	18.3%	0.0	0.0%	36.0	1.8%	660.0	32.2%
Kiltonview	Teesside	Day Unit	175.5	1.7%	0.0	0.0%	1514.2	14.4%	915.0	8.7%	563.2	5.3%	397.5	3.8%
The Orchard	Teesside	Day Unit	35.17	0.6%	0.0	0.0%	797.8	13.7%	0.0	0.0%	427.5	7.4%	120.0	2.1%
Thornaby Road	Teesside	Day Unit	492.1	4.3%	0.0	0.0%	680.8	6.0%	780.0	6.9%	892.5	7.9%	945.0	8.3%

	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 Bank %	Agency Usage vs Actual Hours Agency %	Quality Indicators					Incidents of Restraints				Nursing Average %		Health Care Average %	
					Serious Incidents	L4 Incidents	L3 (Self-Harm) Incidents	No. Complaints	No. of PALS	Number of Incidents	PRO Restraints	Other Restraints Used	Total Number of Restraints Used	Day	Night	Day	Night
Ayckbourn Danby Ward	North Yorkshire	Adults	16.4%	3.3%					4	8	3	13	16	106.1%	100.8%	125.6%	102.7%
Ayckbourn Esk Ward	North Yorkshire	Adults	10.9%	7.2%			9		5	19	2	25	27	80.8%	102.0%	128.1%	110.7%
Bedale Ward	Teesside	Adults	13.2%	12.0%				2	4	131	9	202	211	89.9%	101.2%	137.4%	184.3%
Bilsdale	Teesside	Adults	11.6%	4.4%				4	6	9	1	9	10	94.3%	100.6%	110.0%	110.4%
Birch Ward	Durham & Darlington	Adults	31.0%	5.9%			3		1	47		76	76	91.3%	101.1%	140.8%	141.6%
Bransdale	Teesside	Adults	10.5%	4.0%			1	1	9	16		24	24	100.8%	102.7%	109.9%	107.9%
Cedar	Durham & Darlington	Adults	22.6%	2.2%			2	1	3	137	3	202	205	102.6%	103.4%	102.1%	101.6%
Cedar (NY)	North Yorkshire	Adults	7.0%	55.2%			3	1	9	53	4	74	78	82.7%	138.3%	148.2%	108.7%
Ebor Ward	York and Selby	Adults	9.8%	12.4%			3		7	30		40	40	94.5%	98.9%	84.2%	104.2%
Elm Ward	Durham & Darlington	Adults	22.2%	5.1%	1		10	4	12	43	1	55	56	102.4%	103.0%	93.3%	116.1%
Farnham Ward	Durham & Darlington	Adults	5.5%	2.9%			1	1	14	21	1	31	32	92.5%	104.4%	153.7%	117.3%
Kirkdale	Teesside	Adults	24.2%	3.0%						3	1	4	5	94.3%	100.0%	95.2%	128.1%
Lustrum Vale	Teesside	Adults	33.3%	6.3%			1		1	10		11	11	94.4%	101.8%	187.4%	175.1%
Maple	Durham & Darlington	Adults	26.4%	6.9%			2	2	16	27	2	38	40	89.3%	104.7%	131.3%	161.5%
Minster Ward	York and Selby	Adults	5.7%	12.2%		1			5	35		43	43	99.7%	99.2%	99.2%	108.4%
Overdale	Teesside	Adults	7.8%	7.3%	1	1	3	3	14	32		39	39	97.4%	102.3%	126.0%	127.9%
Primrose Lodge	Durham & Darlington	Adults	10.6%	0.0%				1	5	2		2	2	88.0%	100.0%	106.0%	100.0%
Stockdale	Teesside	Adults	17.2%	5.7%	1				1	21	2	31	33	99.3%	100.8%	110.8%	115.3%
The Orchards (NY)	North Yorkshire	Adults	7.6%	2.0%					1					81.8%	84.9%	105.5%	86.2%
Tunstall Ward	Durham & Darlington	Adults	6.8%	3.0%			2		13	26	6	30	36	111.7%	103.3%	119.1%	117.9%
Ward 15	North Yorkshire	Adults	21.3%	18.8%					4	17		21	21	77.4%	100.1%	149.8%	134.4%
Willow Ward	Durham & Darlington	Adults	17.2%	1.4%	1				7	3		12	12	111.3%	101.4%	128.0%	105.1%

Baysdale	Teesside	CYPS	10.3%	0.0%						1		1	1	124.6%	108.0%	111.5%	106.6%
Holly	Durham & Darlington	CYPS	21.1%	0.5%					1	22		39	39	246.7%	160.9%	276.3%	274.7%
Newberry Centre	Teesside	CYPS	14.3%	7.3%			3	3	6	177	3	248	251	101.1%	119.5%	133.1%	183.6%
The Evergreen Centre	Teesside	CYPS	19.1%	15.8%	1		1	1	7	878	10	1483	1493	80.1%	108.4%	133.6%	179.1%
Westwood Centre	Teesside	CYPS	25.1%	1.9%			6	3	11	961	5	1706	1711	74.0%	73.7%	81.3%	101.6%
Clover / Ivy	Forensics	Forensics LD	29.9%	0.1%						36		70	70	111.4%	105.8%	86.2%	137.0%
Harrier / Hawk	Forensics	Forensics LD	17.5%	0.1%				1	27	5		12	12	94.2%	106.6%	96.4%	100.2%
Kestrel / Kite.	Forensics	Forensics LD	32.9%	2.2%					3	3		3	3	95.2%	106.5%	115.9%	145.2%
Langley	Forensics	Forensics LD	10.9%	0.8%										73.4%	100.0%	94.0%	100.0%
Northdale Centre	Forensics	Forensics LD	32.4%	0.1%					15	11	3	24	27	98.3%	112.9%	103.0%	120.7%
Oakwood	Forensics	Forensics LD	14.8%	0.0%										83.3%	100.7%	220.8%	106.7%
Thistle	Forensics	Forensics LD	15.5%	0.0%					1	61	7	94	101	81.0%	104.0%	109.0%	103.1%
Brambling	Forensics	FMH	34.7%	0.0%			2			78	1	136	137	95.2%	112.4%	138.6%	133.4%
Jay Ward	Forensics	FMH	7.4%	0.0%					2					86.4%	103.6%	96.1%	94.9%
Lark	Forensics	FMH	25.1%	0.0%				1		2		2	2	99.6%	107.3%	105.3%	119.7%
Linnet Ward	Forensics	FMH	18.3%	0.0%						5		7	7	93.1%	104.4%	130.8%	133.9%
Mallard	Forensics	FMH	26.8%	0.0%					30	5		7	7	100.3%	118.8%	135.2%	166.2%
Mandarin	Forensics	FMH	32.0%	0.0%				1	5	38	1	42	43	103.5%	127.4%	145.4%	179.9%
Merlin	Forensics	FMH	25.8%	0.0%				1	2	28	1	51	52	109.6%	103.7%	127.4%	161.7%
Newtondale	Forensics	FMH	11.0%	0.0%					1	3		6	6	106.2%	92.9%	98.7%	112.6%
Nightingale	Forensics	FMH	11.4%	0.0%				2	2	1		1	1	86.4%	106.1%	104.5%	100.3%
Sandpiper Ward	Forensics	FMH	23.5%	0.0%					5	192	15	501	516	100.7%	97.2%	102.6%	129.5%
Swift Ward	Forensics	FMH	12.6%	0.0%			1		1	12		20	20	93.0%	102.7%	96.8%	99.2%
Aysgarth	Teesside	LD	20.1%	0.0%										122.9%	107.3%	96.9%	104.5%
Bankfields Court	Teesside	LD	6.8%	0.0%						102		154	154	112.5%	183.5%	103.6%	104.1%
Bankfields Court Unit 2	Teesside	LD	15.7%	0.0%						1		1	1	113.9%	104.5%	91.5%	103.0%
Bek-Ramsey Ward	Durham & Darlington	LD	13.0%	7.6%				1	1	203	10	377	387	81.8%	108.7%	132.8%	136.3%
Oak Rise	York and Selby	LD	12.3%	19.0%						245		295	295	107.7%	101.9%	127.6%	133.3%
The Lodge	Teesside	LD	4.2%	0.0%						5		5	5	36.4%	25.8%	31.9%	56.0%
Acomb Garth	York and Selby	MHSOP	6.4%	42.3%	1	1				58		73	73	78.6%	95.7%	124.1%	190.3%
Ceddesfeld	Durham & Darlington	MHSOP	6.5%	3.4%	1			2	2	27		33	33	99.3%	100.6%	118.7%	116.4%
Cherry Tree House	York and Selby	MHSOP	10.6%	19.5%	1	1			1	9		10	10	100.4%	105.5%	112.8%	148.2%
Hamsterley	Durham & Darlington	MHSOP	13.7%	7.3%	1				1	24		33	33	104.0%	100.5%	174.2%	179.4%
Meadowfields	York and Selby	MHSOP	21.0%	32.4%						9		9	9	91.6%	99.5%	119.0%	154.1%

Oak Ward	Durham & Darlington	MHSOP	8.7%	5.8%				2	2	16		21	21	99.8%	100.0%	114.6%	124.3%
Roseberry Wards	Durham & Darlington	MHSOP	7.5%	0.0%				1	2	3		3	3	100.7%	100.1%	100.0%	101.1%
Rowan Lea	North Yorkshire	MHSOP	25.2%	16.2%	1	1			2	52	1	69	70	89.1%	100.4%	157.5%	141.9%
Rowan Ward	North Yorkshire	MHSOP	9.6%	36.8%				2		16		22	22	102.6%	143.5%	177.0%	179.3%
Springwood	North Yorkshire	MHSOP	13.1%	15.4%						102		136	136	91.3%	100.4%	126.0%	204.5%
Ward 14	North Yorkshire	MHSOP	13.9%	6.8%										92.7%	93.5%	114.6%	105.2%
Westerdale North	Teesside	MHSOP	9.1%	11.3%	2	1	1			22		25	25	102.4%	107.8%	121.7%	157.8%
Westerdale South	Teesside	MHSOP	30.6%	11.9%										108.7%	79.6%	170.3%	315.2%
Harland Rehab Ward	Durham & Darlington	Rehab	18.3%	0.0%						1		1	1	94.1%	84.3%	36.3%	42.2%
Kiltonview	Teesside	Day Unit	14.4%	0.0%										94.8%		88.2%	
The Orchard	Teesside	Day Unit	13.7%	0.0%										85.1%		81.0%	
Thornaby Road	Teesside	Day Unit	6.0%	0.0%										101.0%		114.0%	101.7%

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 (inc AHPs)	Mandatory Training (May 19)
Ayckbourn Danby Ward	North Yorkshire	Adults			9	26	106.1%	100.8%	125.6%	102.7%	16.4%	3.3%	3.9%	97.05%
Ayckbourn Esk Ward	North Yorkshire	Adults			3	66	80.8%	102.0%	128.1%	110.7%	10.9%	7.2%	0.6%	95.87%
Bedale Ward	Teesside	Adults			10	49	89.9%	101.2%	137.4%	184.3%	13.2%	12.0%	3.5%	97.79%
Bilsdale	Teesside	Adults			5	10	94.3%	100.6%	110.0%	110.4%	11.6%	4.4%	3.2%	94.41%
Birch Ward	Durham and Darlington	Adults			12	19	91.3%	101.1%	140.8%	141.6%	31.0%	5.9%	1.1%	94.04%
Bransdale	Teesside	Adults			2	13	100.8%	102.7%	109.9%	107.9%	10.5%	4.0%	1.4%	98.34%
Cedar	Durham and Darlington	Adults			2	17	102.6%	103.4%	102.1%	101.6%	22.6%	2.2%	1.8%	96.43%
Cedar (NY)	North Yorkshire	Adults			6	82	82.7%	138.3%	148.2%	108.7%	7.0%	55.2%	1.3%	91.61%
Ebor Ward	York and Selby	Adults			8	7	94.5%	98.9%	84.2%	104.2%	9.8%	12.4%	1.5%	95.94%
Elm Ward	Durham and Darlington	Adults			9	38	102.4%	103.0%	93.3%	116.1%	22.2%	5.1%	2.2%	93.77%
Farnham Ward	Durham and Darlington	Adults			4	17	92.5%	104.4%	153.7%	117.3%	5.5%	2.9%	0.6%	92.38%
Kirkdale	Teesside	Adults			5	6	94.3%	100.0%	95.2%	128.1%	24.2%	3.0%	3.9%	95.50%
Lustrum Vale	Teesside	Adults			6	10	94.4%	101.8%	187.4%	175.1%	33.3%	6.3%	1.7%	94.50%
Maple	Durham and Darlington	Adults			17	31	89.3%	104.7%	131.3%	161.5%	26.4%	6.9%	1.5%	92.66%
Minster Ward	York and Selby	Adults			12	47	99.7%	99.2%	99.2%	108.4%	5.7%	12.2%	4.7%	96.65%
Overdale	Teesside	Adults	1		3	13	97.4%	102.3%	126.0%	127.9%	7.8%	7.3%	3.3%	94.52%
Primrose Lodge	Durham and Darlington	Adults			2		88.0%	100.0%	106.0%	100.0%	10.6%	0.0%	0.6%	93.75%
Stockdale	Teesside	Adults			7	21	99.3%	100.8%	110.8%	115.3%	17.2%	5.7%	2.4%	95.24%
The Orchards (NY)	North Yorkshire	Adults			3	6	81.8%	84.9%	105.5%	86.2%	7.6%	2.0%	2.7%	
Tunstall Ward	Durham and Darlington	Adults			2	41	111.7%	103.3%	119.1%	117.9%	6.8%	3.0%	1.8%	96.80%
Ward 15	North Yorkshire	Adults			2		77.4%	100.1%	149.8%	134.4%	21.3%	18.8%	1.2%	87.20%
Willow Ward	Durham and Darlington	Adults			13	9	111.3%	101.4%	128.0%	105.1%	17.2%	1.4%	1.8%	96.74%

Baysdale	Teesside	CYPS		1	8	14	124.6%	108.0%	111.5%	106.6%	10.3%	0.0%	4.6%	96.03%
Holly	Durham and Darlington	CYPS			1	14	246.7%	160.9%	276.3%	274.7%	21.1%	0.5%	16.9%	93.33%
Newberry Centre	Teesside	CYPS			1	204	101.1%	119.5%	133.1%	183.6%	14.3%	7.3%	7.5%	97.06%
The Evergreen Centre	Teesside	CYPS			13	190	80.1%	108.4%	133.6%	179.1%	19.1%	15.8%	2.6%	87.55%
Westwood Centre	Teesside	CYPS			11	202	74.0%	73.7%	81.3%	101.6%	25.1%	1.9%	4.6%	90.25%
Clover / Ivy	Forensics	Forensics LD			3	8	111.4%	105.8%	86.2%	137.0%	29.9%	0.1%	1.2%	97.84%
Harrier / Hawk	Forensics	Forensics LD			6	10	94.2%	106.6%	96.4%	100.2%	17.5%	0.1%	4.0%	98.98%
Kestrel / Kite.	Forensics	Forensics LD			6	15	95.2%	106.5%	115.9%	145.2%	32.9%	2.2%	1.7%	95.37%
Langley	Forensics	Forensics LD			1	7	73.4%	100.0%	94.0%	100.0%	10.9%	0.8%	0.8%	98.02%
Northdale Centre	Forensics	Forensics LD			13	33	98.3%	112.9%	103.0%	120.7%	32.4%	0.1%	3.4%	96.03%
Oakwood	Forensics	Forensics LD			3	9	83.3%	100.7%	220.8%	106.7%	14.8%	0.0%	4.6%	98.16%
Thistle	Forensics	Forensics LD			9	24	81.0%	104.0%	109.0%	103.1%	15.5%	0.0%	1.1%	97.01%
Brambling	Forensics	Forensics MH			26	40	95.2%	112.4%	138.6%	133.4%	34.7%	0.0%	1.4%	95.98%
Jay Ward	Forensics	Forensics MH			3	10	86.4%	103.6%	96.1%	94.9%	7.4%	0.0%	3.1%	99.24%
Lark	Forensics	Forensics MH			6	44	99.6%	107.3%	105.3%	119.7%	25.1%	0.0%	2.7%	96.51%
Linnet Ward	Forensics	Forensics MH			8	35	93.1%	104.4%	130.8%	133.9%	18.3%	0.0%	2.7%	98.04%
Mallard	Forensics	Forensics MH		1	18	18	100.3%	118.8%	135.2%	166.2%	26.8%	0.0%	2.3%	96.66%
Mandarin	Forensics	Forensics MH			9	25	103.5%	127.4%	145.4%	179.9%	32.0%	0.0%	1.7%	98.77%
Merlin	Forensics	Forensics MH			1	31	109.6%	103.7%	127.4%	161.7%	25.8%	0.0%	3.0%	99.81%
Newtondale	Forensics	Forensics MH			6	18	106.2%	92.9%	98.7%	112.6%	11.0%	0.0%	2.9%	99.65%
Nightingale	Forensics	Forensics MH			3	18	86.4%	106.1%	104.5%	100.3%	11.4%	0.0%	2.4%	94.96%
Sandpiper Ward	Forensics	Forensics MH			8	28	100.7%	97.2%	102.6%	129.5%	23.5%	0.0%	2.3%	95.27%
Swift Ward	Forensics	Forensics MH			1	17	93.0%	102.7%	96.8%	99.2%	12.6%	0.0%	4.1%	96.94%
Aysgarth	Teesside	LD			2	18	122.9%	107.3%	96.9%	104.5%	20.1%	0.0%	3.8%	97.22%
Bankfields Court	Teesside	LD			4	18	112.5%	183.5%	103.6%	104.1%	6.8%	0.0%	5.3%	95.29%
Bankfields Court Unit 2	Teesside	LD			9	20	113.9%	104.5%	91.5%	103.0%	15.7%	0.0%	5.7%	89.56%
Bek-Ramsey Ward	Durham and Darlington	LD			6	29	81.8%	108.7%	132.8%	136.3%	13.0%	7.6%	7.0%	91.84%
Oak Rise	York and Selby	LD			6	55	107.7%	101.9%	127.6%	133.3%	12.3%	19.0%	4.7%	91.10%
The Lodge	Teesside	LD				1	36.4%	25.8%	31.9%	56.0%	4.2%	0.0%	1.9%	
Acomb Garth	York and Selby	MHSOP	1		3	33	78.6%	95.7%	124.1%	190.3%	6.4%	42.3%	0.5%	95.30%
Ceddesfeld	Durham and Darlington	MHSOP			3	1	99.3%	100.6%	118.7%	116.4%	6.5%	3.4%	2.2%	96.19%
Cherry Tree House	York and Selby	MHSOP	1	1	11	9	100.4%	105.5%	112.8%	148.2%	10.6%	19.5%	4.2%	97.67%

Hamsterley	Durham and Darlington	MHSOP			5	6	104.0%	100.5%	174.2%	179.4%	13.7%	7.3%	1.0%	93.68%
Meadowfields	York and Selby	MHSOP			11	9	91.6%	99.5%	119.0%	154.1%	21.0%	32.4%	1.9%	94.71%
Oak Ward	Durham and Darlington	MHSOP		1	11	6	99.8%	100.0%	114.6%	124.3%	8.7%	5.8%	1.6%	95.95%
Roseberry Wards	Durham and Darlington	MHSOP		1	1	10	100.7%	100.1%	100.0%	101.1%	7.5%	0.0%	0.1%	96.45%
Rowan Lea	North Yorkshire	MHSOP	1	2	4	28	89.1%	100.4%	157.5%	141.9%	25.2%	16.2%	2.6%	93.68%
Rowan Ward	North Yorkshire	MHSOP		2	9	18	102.6%	143.5%	177.0%	179.3%	9.6%	36.8%	1.1%	88.98%
Springwood	North Yorkshire	MHSOP			8	53	91.3%	100.4%	126.0%	204.5%	13.1%	15.4%	2.9%	94.76%
Ward 14	North Yorkshire	MHSOP			1		92.7%	93.5%	114.6%	105.2%	13.9%	6.8%	3.5%	
Westerdale North	Teesside	MHSOP	1	1	9	25	102.4%	107.8%	121.7%	157.8%	9.1%	11.3%	1.7%	97.35%
Westerdale South	Teesside	MHSOP			2	44	108.7%	79.6%	170.3%	315.2%	30.6%	11.9%	0.9%	88.71%
Harland Rehab Ward	Durham and Darlington	Rehab					94.1%	84.3%	36.3%	42.2%	18.3%	0.0%	4.4%	
Kiltonview	Teesside	Day Unit				1	94.8%		88.2%		14.4%	0.0%	1.7%	
The Orchard	Teesside	Day Unit					85.1%		81.0%		13.7%	0.0%	0.6%	95.09%
Thornaby Road	Teesside	Day Unit				19	101.0%		114.0%	101.7%	6.0%	0.0%	4.3%	99.10%

Care Hours per Patient Day

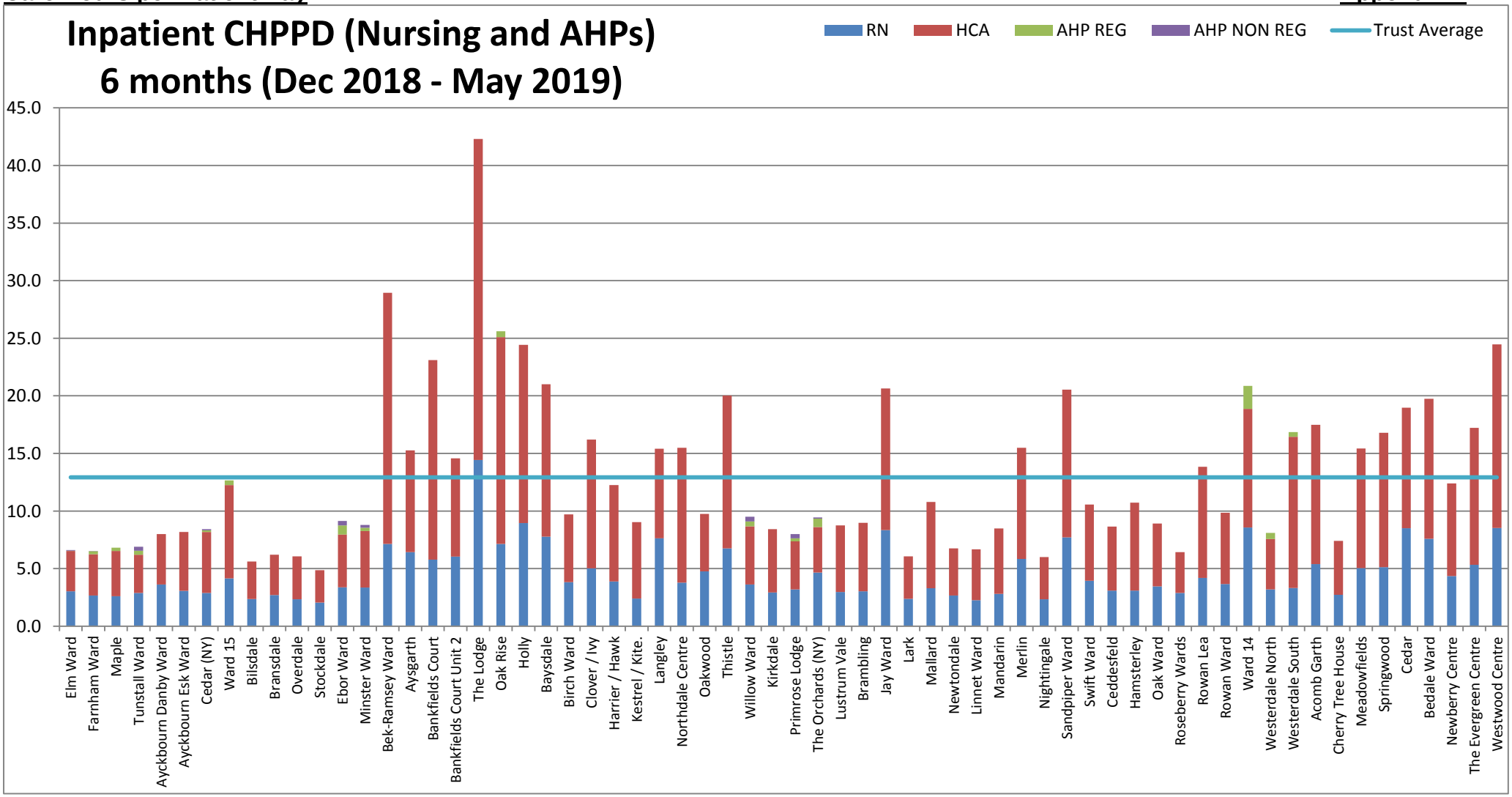
APPENDIX 6

Ward Name	Locality	Speciality	Occupied Bed at Midnight							RN Hours	HCA Hours	AHP REG Hours	AHP NON-REG Hours	Care Hours per Patient Day				
			Dec	Jan	Feb	Mar	Apr	May	TOTAL					RN	HCA	AHP REG	AHP NON REG	Overall
Elm Ward	Durham & Darlington	ACUTE	429	424	446	531	504	547	2881	8769.5	10062.3	45.0	157.5	3.0	3.5	0.0	0.1	6.6
Farnham Ward	Durham & Darlington	ACUTE	513	590	520	585	515	539	3262	8706.3	11683.5	852.0	33.0	2.7	3.6	0.3	0.0	6.5
Maple	Durham & Darlington	ACUTE	569	512	440	588	523	518	3150	8199.0	12417.9	892.5	0.0	2.6	3.9	0.3	0.0	6.8
Tunstall Ward	Durham & Darlington	ACUTE	521	517	479	567	557	476	3117	9036.8	10321.6	1101.7	1032.0	2.9	3.3	0.4	0.3	6.9
Danby Ward	North Yorkshire	ACUTE	357	373	344	402	359	363	2198	7983.0	9612.3			3.6	4.4			8.0
Esk Ward	North Yorkshire	ACUTE	344	367	313	321	311	306	1962	6041.1	10033.8			3.1	5.1			8.2
Cedar (NY)	North Yorkshire	ACUTE	421	386	375	398	423	434	2437	7030.1	12915.7	324.5	291.5	2.9	5.3	0.1	0.1	8.4
Ward 15	North Yorkshire	ACUTE	378	260	72				710	2952.8	5755.0	285.0	0.0	4.2	8.1	0.4	0.0	12.7
Bilsdale	Teesside	ACUTE	604	565	379	451	395	418	2812	6640.9	9151.8	0.0	0.0	2.4	3.3	0.0	0.0	5.6
Bransdale	Teesside	ACUTE	475	463	396	432	402	396	2564	6969.3	8965.4	0.0	0.0	2.7	3.5	0.0	0.0	6.2
Overdale	Teesside	ACUTE	366	411	478	548	530	497	2830	6640.4	10514.8	0.0	0.0	2.3	3.7	0.0	0.0	6.1
Stockdale	Teesside	ACUTE	547	571	529	592	494	539	3272	6703.3	9214.5	0.0	0.0	2.0	2.8	0.0	0.0	4.9
Ebor Ward	York and Selby	ACUTE	360	358	327	326	344	369	2084	7034.5	9547.9	1669.5	810.0	3.4	4.6	0.8	0.4	9.1
Minster Ward	York and Selby	ACUTE	340	347	305	371	337	353	2053	6913.9	10049.1	577.0	536.5	3.4	4.9	0.3	0.3	8.8
Bek-Ramsey	Durham & Darlington	ALD	178	178	164	158	121	141	940	6709.3	20501.7			7.1	21.8			28.9
Aysgarth	Teesside	ALD	120	128	120	121	131	135	755	4858.0	6672.9			6.4	8.8			15.3
Bankfields	Teesside	ALD	341	317	273	286	349	369	1935	11170.2	33540.7			5.8	17.3			23.1
Unit 2	Teesside	ALD	116	120	107	129	123	141	736	4453.3	6268.8			6.1	8.5			14.6
The Lodge	Teesside	ALD	31	31	28	4	0	0	94	1356.9	2618.3	0.0	0.0	14.4	27.9	0.0	0.0	42.3
Oak Rise	York and Selby	ALD	186	186	168	186	180	186	1092	7807.1	19591.9	566.7	0.0	7.1	17.9	0.5	0.0	25.6
Holly	Durham & Darlington	CLD	65	74	60	103	62	59	423	3792.8	6540.0	0.0	0.0	9.0	15.5	0.0	0.0	24.4
Baysdale	Teesside	CLD	120	125	124	126	129	126	750	5838.9	9917.2			7.8	13.2			21.0
Birch Ward	Durham & Darlington	EATING DISORDERS	386	392	333	340	364	349	2164	8277.4	12757.9			3.8	5.9			9.7

Clover / Ivy	Forensics	FLD	259	248	199	217	210	235	1368	6877.9	15279.6			5.0	11.2			16.2
Harrier / Hawk	Forensics	FLD	310	310	280	310	287	279	1776	6921.1	14830.2			3.9	8.4			12.2
Kestrel / Kite.	Forensics	FLD	496	496	448	496	480	496	2912	6974.4	19358.2	0.0	0.0	2.4	6.6	0.0	0.0	9.0
Langley	Forensics	FLD	96	124	112	119	150	155	756	5765.6	5877.5	0.0	0.0	7.6	7.8	0.0	0.0	15.4
Northdale	Forensics	FLD	341	335	308	328	300	310	1922	7272.3	22490.8	0.0	0.0	3.8	11.7	0.0	0.0	15.5
Oakwood	Forensics	FLD	233	226	196	217	223	248	1343	6392.9	6706.5	0.0	0.0	4.8	5.0	0.0	0.0	9.8
Thistle	Forensics	FLD	155	155	140	155	150	155	910	6144.9	12075.5	0.0	0.0	6.8	13.3	0.0	0.0	20.0
Willow Ward	Durham & Darlington	HIGH DEPENDENCY REHABILITATION	356	317	271	355	344	355	1998	7253.3	10086.8	832.5	807.0	3.6	5.0	0.4	0.4	9.5
Kirkdale	Teesside	LOCKED REHAB	279	399	378	442	394	367	2259	6644.3	12377.8			2.9	5.5			8.4
Primrose Lodge	Durham & Darlington	LONGER TERM COMPLEX / CONTINUING CARE	365	369	357	346	359	354	2150	6869.2	8981.7	581.0	768.5	3.2	4.2	0.3	0.4	8.0
The Orchards (NY)	North Yorkshire	LONGER TERM COMPLEX / CONTINUING CARE	179	237	249	271	260	236	1432	6679.5	5658.0	1046.2	135.8	4.7	4.0	0.7	0.1	9.4
Lustrum Vale	Teesside	LONGER TERM COMPLEX / CONTINUING CARE	544	495	400	407	381	376	2603	7737.4	15042.5			3.0	5.8			8.8
Brambling	Forensics	LOW SECURE	354	367	364	406	413	393	2297	6957.5	13655.6			3.0	5.9			9.0
Jay Ward	Forensics	LOW SECURE	110	154	132	125	132	125	778	6489.7	9561.3			8.3	12.3			20.6
Lark	Forensics	LOW SECURE	527	508	448	523	510	496	3012	7163.9	11102.2			2.4	3.7			6.1
Mallard	Forensics	LOW SECURE	360	390	381	383	360	388	2262	7472.4	16915.7			3.3	7.5			10.8
Newtondale	Forensics	LOW SECURE	595	555	534	588	568	582	3422	9136.4	13997.4			2.7	4.1			6.8
Linnet Ward	Forensics	MEDIUM SECURE	512	516	439	514	510	527	3018	6833.5	13316.5			2.3	4.4			6.7
Mandarin	Forensics	MEDIUM SECURE	496	473	420	465	450	490	2794	7848.2	15879.9			2.8	5.7			8.5
Merlin	Forensics	MEDIUM SECURE	310	310	268	286	245	247	1666	9731.2	16076.6			5.8	9.6			15.5
Nightingale	Forensics	MEDIUM SECURE	463	449	432	489	466	496	2795	6532.2	10240.3			2.3	3.7			6.0
Sandpiper Ward	Forensics	MEDIUM SECURE	217	217	196	188	157	195	1170	9016.7	15021.3	0.0	0.0	7.7	12.8	0.0	0.0	20.5
Swift Ward	Forensics	MEDIUM SECURE	310	284	245	297	295	292	1723	6806.7	11381.4	0.0	0.0	4.0	6.6	0.0	0.0	10.6
Ceddesfeld	Durham & Darlington	OLDER ADULTS - ACUTE	294	405	328	435	428	402	2292	7104.8	12742.9			3.1	5.6			8.7

Hamsterley	Durham & Darlington	OLDER ADULTS - ACUTE	453	479	376	397	332	334	2371	7347.1	18086.9			3.1	7.6			10.7
Oak Ward	Durham & Darlington	OLDER ADULTS - ACUTE	344	326	326	365	326	363	2050	7087.3	11186.5			3.5	5.5			8.9
Roseberry Wards	Durham & Darlington	OLDER ADULTS - ACUTE	417	406	385	434	407	399	2448	7083.3	8689.9			2.9	3.5			6.4
Rowan Lea	North Yorkshire	OLDER ADULTS - ACUTE	428	411	367	277	235	240	1958	8228.5	18891.1			4.2	9.6			13.9
Rowan Ward	North Yorkshire	OLDER ADULTS - ACUTE	383	439	369	421	448	353	2413	8860.9	14906.8			3.7	6.2			9.8
Ward 14	North Yorkshire	OLDER ADULTS - ACUTE	165	149	40				354	3032.3	3650.8	701.7	0.0	8.6	10.3	2.0	0.0	20.9
Westerdale North	Teesside	OLDER ADULTS - ACUTE	532	422	419	508	468	472	2821	8993.3	12365.8	1504.9	0.0	3.2	4.4	0.5	0.0	8.1
Westerdale South	Teesside	OLDER ADULTS - ACUTE	359	332	259	345	303	266	1864	6198.2	24465.9	759.5	0.0	3.3	13.1	0.4	0.0	16.9
Acomb Garth	York and Selby	OLDER ADULTS - ACUTE	306	286	236	257	275	262	1622	8757.0	19613.8			5.4	12.1			17.5
Cherry Tree House	York and Selby	OLDER ADULTS - ACUTE	452	537	457	421	423	480	2770	7566.7	12972.2			2.7	4.7			7.4
Meadowfields	York and Selby	OLDER ADULTS - ACUTE	309	301	232	205	146	147	1340	6758.8	13908.5			5.0	10.4			15.4
Springwood	North Yorkshire	OTHER SPECIALIST MENTAL HEALTH BEDS	226	235	206	217	210	217	1311	6723.0	15297.6			5.1	11.7			16.8
Cedar	Durham & Darlington	PICU	292	217	214	201	227	211	1362	11576.5	14272.3			8.5	10.5			19.0
Bedale Ward	Teesside	PICU	278	231	170	203	232	249	1363	10360.9	16551.5			7.6	12.1			19.7
Newberry Centre	Teesside	TIER 4	299	309	317	386	382	304	1997	8692.8	16058.8			4.4	8.0			12.4
The Evergreen Centre	Teesside	TIER 4	358	310	265	326	299	320	1878	10034.0	22299.7			5.3	11.9			17.2
Westwood Centre	Teesside	TIER 4	225	186	161	130	181	186	1069	9109.9	17044.0			8.5	15.9			24.5
Harland Rehab Ward	Durham & Darlington		31	8					39	1092.3	960.0	0.0	0.0	28.0	24.6	0.0	0.0	52.6
Thornaby Road	Teesside		155	155	140	155	150	155	910	3280.1	8052.2	0.0	0.0	3.6	8.8	0.0	0.0	12.5

Care Hours per Patient Day **Appendix 7**



Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Thursday 18 July 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 04 July 2019

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 Durham and Darlington and Forensic Services
- Compliance with CQC
- Claims Report
- Patient Safety
- Safeguarding & Public Protection
- Positive and Safe Update
- Health, Safety, Security and Fire

Recommendations:

That the Board of Directors:

- Note the request for an extraordinary QuAC meeting to be held during August 2019 to specifically discuss issues relating to West Lane Hospital.
- Receive and note the report of the Quality Assurance Committee from its meeting held on 04 July 2019.
- Note the confirmed minutes of the formal meeting held on 06 June 2019 (Annex 1)

MEETING OF:	**Board of Directors**
DATE:	**Thursday 18 July 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 any concerns and exceptions, together with levels of assurance in meeting the CQC fundamental high quality questions.

2. BACKGROUND INFORMATION AND CONTEXT

This report makes reference to the regular assurance and exception reports from the working groups of the Quality Assurance Committee, the localities and compliance with the Care Quality Commission regulatory standards.

3. KEY ISSUES

Are our Services 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?*

4.1 Durham & Darlington Locality

The Committee discussed the Durham and Darlington LMGB report covering the period March 2019 – May 2019.

The key concerns highlighted were:

(i) Pressures in Inpatient and community services, Adult Mental Health. There are high referrals in to the service and also numbers waiting, with 59 cases in Easington unallocated due to staff vacancies and high caseload numbers. Solutions being considered are Mind the Gap arrangements and increasing non-medical Prescribers.

(ii) Medical Recruitment – some improvements have been seen recently with the appointment of a Consultant and there are plans to try to recruit from India in January 2020. It is expected that it will take at least a year before recruitment issues are stabilised.

(iii) Breaching the KPI for second appointment within 9 weeks in Children and Young People's services, however the 4 week target is still being met. A deep dive is underway to identify what can be done to meet the demands. Psycho-education groups for low/moderate anxiety and low mood have helped to create some capacity and reduce the 9 week waits.

(iv) Pressure in Learning Disability Inpatient Services. There are complexities around a patient from York where it would be detrimental to their wellbeing for them to be moved, however they continue to damage the physical environment and have a negative impact on the ability to flexibly manage the six beds across Bek and Ramsey.

(v) As part of the regular reporting to QuAC, exceptions around checks on resuscitation bags have been found in Cedar, Maple, Elm and Bek Ramsey and assurance was provided to the Committee that additional monitoring has been put in place. It was noted that some of these missing checks had been due to the presence of agency staff on the ward.

There has been a single incident of using mechanical restraint in PICU Cedar ward in April 2019.

Members of the Committee expressed their concern around the potential of staff to move to the Trust as working employees from Whorlton Hall. It was noted that this has been picked up by HR to ensure the process is managed and recruiting staff would be aware if this was the case.

4.2 Forensic Services

The Committee discussed the Forensic LMGB report for the period April to May 2019.

The key concerns highlighted were:

(i) Service restructure. Oakwood and Talbot are the locked rehabilitation wards within Health and Justice. To ensure there is an effective information flow between the Inpatient settings the Service Manager from these wards will now attend the Secure Inpatient Service QuAG. Resuscitation equipment. During the two month reporting period there was an issue with missing signatures/checks and an issue with the use of the approved form. These were addressed immediately and action taken through supervision or informal counselling as appropriate.
Further assurance was provided that the audit tool has been revised to reflect the Trust policy and this has now been adopted Trust wide.

(ii) Restrictive practice and interventions. Assurance was provided that there is an ongoing focus on any restrictive practices within the inpatient units and how they can be reduced, with challenge around the rationale. Consideration is being given to how service users can be involved in the decision making and the Equality and Diversity lead will help to explore questioning from a human rights perspective.

(iii) There had been 11 uses of soft restraint devices and 12 uses of tear proof clothing during the two month period.

(iv) Members expressed their concerns over the staff absence rates on several wards, which is over 20%, due to a range of issues including physical illness which then impacts on the remaining staff and leads to stress related sickness. The wards worst affected were LD and it was noted that the transforming care agenda, leading to staff moving 3 or 4 times had made the problem worse and affected morale. There is a shortage of 62 WTE at the moment and included in this are 35 expectant mums and/or on maternity leave on 16 wards.

4.3 Compliance with CQC Requirements

The Committee received the monthly update on compliance with CQC registration requirements.

The Board is to note:

(i) There was an unannounced visit to Children and Young People's Services to Baysdale Unit at Roseberry Park, Holly Unit at West Lane and Westwood, Newberry and Evergreen Centre at West Lane Hospital.

(ii) The visit to West Lane was a responsive inspection due to concerns raised to the CQC. A draft inspection report will be shared with the Trust with the opportunity for comments on factual accuracy.

(iii) The CQC have issued a notice of decision against the Trust due to concerns identified in the inspection under Section 31 of the Health and Social Care Act, this relates to issues with staffing, observations and medicines management relating to West Lane wards only. The unit has also been suspended from taking any new admissions.

(iv) Members of QuAC agreed that there should be an Extraordinary meeting held of the Quality Assurance Committee in August 2019 to give due consideration to the details around this inspection.

(v) The CQC have sent a Provider Information Request (PIR) to be completed by 16 July 2019, to inform the Trust of the start of a full well-led inspection within the next six months.

(vi) Outstanding actions (11) from the 2018 well-led inspection were being followed up, mainly relating to evidence not yet sent to the Compliance Team.

4.4 Claims Report

The Committee received a summary of claims that have been managed by the organisation over the last three financial years and the cost implications.

Assurance can be provided to the Board that there are robust claims management and investigation processes together with awareness raising to services which will ensure that early decisions are able to be made on claims to keep costs to a minimum and protect the reputation of the organisation.

ARE OUR SERVICES SAFE? *Are lessons learned and improvements made when things go wrong?*

5.0 Patient Safety Group and Annual Report

The Committee received the assurance report of the Patient Safety Group and the Patient Safety Annual Report 2018/19.

The key matters for Board members to note are:

(i) Clarification was provided that the numbers of expected deaths by severity in 2018/19 (1,217) included deaths in the community and those patients who die from physical health/natural causes.

(ii) QuAC members requested further details around tier 4 incidents in CAMHS and this would be included for discussion at the Extraordinary Quality Assurance Committee meeting to be held in August 2019.

(iii) A focus was being given to learning from root causes and/or contributory findings from the serious incident reviews and the locality with the highest proportion (61%) was York and Selby, however there had been some reduction from the previous year. The percentage of reports requiring a formal action plan within NY, Teesside and Durham and Darlington have all reduced.

5.1 Positive and Safe Dashboard

The Committee discussed the Positive and Safe Dashboard.

The Board is to note the following:

(i) This report included two dashboards, a weekly snapshot providing information around a number of key indicators relating to the use of restrictive practice together with a monthly view using the same key indicators, over the period May 2017 to April 2018. The weekly dashboard is being used weekly in clinical huddles to inform operational practice.

(ii) Members of the Committee requested that the LMGB reports from localities include the dashboards in their reports to QuAC from September 2019 with a narrative around any trends or spikes.

(iii) By speciality the only concerning trend relates to NY and York LD services in relation to the number of physical interventions and self-harm. All other localities show a downward trend or are within normal variation.

(iv) Risks relating to the use of physical intervention and management of challenging service users will be managed through operational services and work within the Positive and Safe team.

(v) Assurance can be provided that the data demonstrates a downward trend in the use of tear proof clothing.

5.2 Health, Safety, Security and Fire

The key matters for the Board to be aware of are:

(i) There were no risks reported overall from the six monthly reporting period around health, safety, security and fire matters.

(ii) It was noted that that number of incidents reported to the police (68 in 2018/19, compared to 62 in 2017/18) and any outcome of these after being pursued by the Police was reliant on the injured persons to give feedback on any actions taken against the perpetrator by the Police or court.

(iii) There has been significant improvement in the incidents of smoking inside and out of premises with a reduction from 338 in 2017/18 to 180 this year.

5.3 Safeguarding and Public Protection

The Committee received an exception report for safeguarding.

The Board is to note:

(i) The Durham Safeguarding Adult Board will undertake a serious adult review regarding Whorlton Hall.

(ii) A further meeting will take place in July 2019 following the safeguarding enquiries at Acomb Garth. The first two meeting dates had been changed by York Local Authority.

(iii) There will be a review held by the local authority in Durham, under the Child Death Review Process of the young person who went from Newberry ward to James Cook Hospital and sadly died.

6. IMPLICATIONS

6.1 **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. CONCLUSIONS

The Quality Assurance Committee considered the corporate assurance and performance reports during the meeting.

8. RECOMMENDATIONS

That the Board of Directors is asked to:

(i) Note the issues raised at the Quality Assurance Committee meeting on 04 July 2019.

(ii) Note the confirmed formal minutes of the meeting held on 06 June 2019.

Dr Hugh Griffiths
Chairman of Quality Assurance Committee
18 July 2019

Item 1

NOTES OF THE FORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 06 JUNE 2019, IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Ms Miriam Harte, Chairman of the Trust
Dr Hugh Griffiths, Chairman of the Committee
Mr Colin Martin, Chief Executive
Mrs Shirley Richardson, Non-Executive Director
Dr Ahmad Khouja, Medical Director
Mrs Jennifer Illingworth, Director of Quality Governance
Mr Richard Simpson, Non-Executive Director

In attendance:
Mrs Sharon Pickering, Director of Planning, Performance & Communications
Mr Dominic Gardner, Director of Operations, Tees
Mrs Karen Atkinson, Head of Nursing, Tees
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mrs Karen Agar, Associate Director of Nursing (for minute 19/80)
Mr Chris Williams, Chief Pharmacist (for minute 19/81)
Professor Joe Reilly, Clinical Director for Research & Development (for minute19/82)
Mrs Sarah Jay, Equality and Diversity Lead (for minute 19/83)
Mrs Ann Marshall, Deputy Director of Nursing
Mrs Hazel Griffiths, Governor, North Yorkshire
Mr Alan Williams, Governor, Redcar & Cleveland
Dr Sarah Hopper, Consultant Applied Psychologist, Tees
Bethany Thomson, Community Nurse, Roseberry Park Hospital

19/73 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs Ruth Hill, Chief Operating Officer, Mrs Elizabeth Moody, Director of Nursing & Governance and Dr Lenny Cornwall, Deputy Medical Director, Tees,

19/74 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 02 May 2019 were accepted as a true recording of the discussion and signed by the Chairman.

19/75 ACTION LOG

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

18/151 Work to be undertaken to the Patient Experience Report to pull out meaningful data and information, to include narrative and analysis framed around the CQC high quality questions in order to provide QuAC with higher levels of assurance and any exceptions.
The report had started to develop according to the request of QuAC and for the report to be standardised with other reports. This report would come back to QuAC in September 2019.

18/170 Report on automated defibrillators was deferred to the July 2019 QuAC meeting.

19/04	Discussion to take place about correlating the longer view of acuity on wards linked to patients feeling safe. It was noted that this work was underway to correlate information from patient experience which would be led by Jo Whitelock not Jo Dent as it had stated on the action log. This would come back to QuAC in September 2019.
19/08	Update on migrating uncoded allergies on Paris. This matter was covered under agenda item number 8 (minute 19/81 refers). **Completed**
19/40	Tees LMGB report, check algorithm for level 3 self-harm. This matter was covered under agenda item number 3 (minute 19/76 refers). **Completed**
19/41	Tees service to consider replacing plastic crockery on the wards. This matter was covered under agenda item number 3 (minute 19/76 refers). **Completed**
19/57c	Forensic LMGB report: to look in more detail at the scorecard 54% response for staff treated with dignity and respect. This would be considered at the July QuAC meeting when the locality would be present.
19/60	IPC report to June QuAC meeting. The report was covered under agenda item number 6 (minute 19/79 refers). **Completed**

19/76 TEES SERVICES LMGB REPORT

The Committee received and noted the Tees Services LMGB Report.

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

- The high levels of bed occupancy in Adult Mental Health and some out of the area placements largely related to MHSOP.
- Activity levels within Adult Mental Health Services and Children and Young People's Services, coupled with sickness absence, which was causing pressure on the services.
  Some work was underway with the Performance Team to look at demand and capacity, which had seen a surge in the last three years, possibly related to when the provision of IAPT services ceased.
  Assurance was provided to members that the sickness absence amongst staff was not linked to pressures of work and that the long term sickness numbers were starting to come down with around 40 members off long term currently.
- Work was underway to understand the increase in the rates of seclusion; however it was thought by the Service that there was a degree of double reporting from AMH and PICU as well as some individuals with multiple episodes of seclusion.
  Members noted how important it was to get the right balance for restrictive approaches and to ensure that individuals were placed in seclusion for appropriate periods of time.

  The Chairman requested further evidence on tracking and understanding the 'arousal cycle' for individuals place in seclusion and a conversation would take place with Dr Cornwall, Deputy Medical Director with some information included in the locality report for September 2019.
  Action: Mr D Gardner

- A safeguarding referral made in Westerdale North, MH Services for Older People in relation to the potential inappropriate movement of a patient by staff. The CQC had been informed and an investigation was underway.

- The use of tear resistant clothing had been used on one occasion, during an episode of seclusion.
- Resuscitation equipment – all had been checked on a daily basis in line with policy with the exception of five checks across wards.
  Further assurance was sought from the members of the Committee on actions that had been taken to address the areas which were found to be non-compliant.

  Following discussion it was noted that there was a national problem with the shortage of LD nurses and this was clearly impacting on Tees. Some Universities had stopped funding the courses to train LD nurses, however the Trust was slightly better off than other parts of the country as some joint working with Universities was ensuring that the courses were still being run.

19/77 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

The Committee received and noted an update report on Compliance with CQC Registration Requirements.

The following key matters were highlighted from the report:

- The CQC continued to monitor progress on the actions following the well-led inspection as part of the regular engagement meetings. EMT had discussed the position on actions on 21 May 2019, which were mainly in relation to the need for evidence to be provided to the Compliance Team.
- Members considered the recent four MHA inspections and the common themes which had been raised. There had been an issue raised around the placing of some CCTV cameras and this was being resolved.
- The CQC have started a thematic review of restraint, prolonged seclusion and segregation in to services for people with a Learning Disability and also Tier 4 Children and Young Peoples services. Inspections had taken place at West Lane and would be due to continue on Lanchester Road site on the 11th June 2019. The Trust would not receive formal feedback from these reviews but would be included within the final report to be published by the CQC in spring 2020.

  Members discussed the recent screening on TV by Panorama of issues at Whorlton Hall and the inadequate care that had been provided and considered whether there might be a change in the approach to future CQC inspections. At a recent national engagement meeting this had been alluded to however the thinking was that there might be more unannounced inspections.

  Mrs Illingworth highlighted the different culture amongst different healthcare and community settings and that there was an openness with TEWV staff and CQC inspectors.

19/78 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Safety Group Report. (The patient Safety Data had not been included in the report submitted for the meeting and would be circulated following the meeting).

Action: Mrs J Illingworth

The key matters highlighted from the report were:

- It had been seen in several SI's that patients who had multiple teams and agencies involved in their care often did not have a single responsible organisation taking overview of what care was provided

and by who. This was being picked up by the Right Care Right Place work stream and the Trust learning event planned for early July 2019.

- It had been highlighted there was no single communication system for GPs and this had come up in an SI where a GP had changed a patients psychiatric medication unaware that the patient was being seen in MH services. Work was underway to look at how improvements could be made.
- It had been found that there was duplication around the recording of fall. This was being addressed and all reviews of fractured neck of femur would remain with the Falls Team.

Following discussion around the increase of 26 incidents of level 3 self-harm reported in Q4 with a total of 93 it was noted that there was little change in Tier 4. Durham and Darlington reported the most with 39 incidents with three teams as potential outliers. Dr Khouja gave members an overview of these three teams and members expressed caution around checking next month's data to see if there was any correlation.

19/79 INFECTION, PREVENTION AND CONTROL ANNUAL REPORT

The Committee received the Infection, Prevention and control Annual Report 2018/19.

Members discussed the compliance rates around the influenza campaign and sought assurance that plans were in place for the next flu campaign running in the current year. It was highlighted that there had been a number of deaths locally due to influenza amongst fit and healthy people and it was important that the potential seriousness of influenza be communicated to all staff and patients.

It was noted that there were now going to be two flu vaccinators in every team and communications would include the message around "We wish we had had the flu jab", from members of staff that had suffered with flu last year.

The Chairman of the Committee queried the information on page 8 of the report around the environmental audits undertaken during 2018/19 and how many were returned.

Mrs Marshall undertook to look into the details of this, however it was confirmed that there is an escalation process whereby if audits did not get completed twice it would be passed to the Modern Matron.

Action: Mrs A Marshall

19/80 SAFEGUARDING AND PUBLIC PROTECTION EXCEPTION REPORT, SAFEGUARDING SIX MONTHLY REPORT & SAFEGUARDING ANNUAL REPORT 2018/19

The Committee received an exception report for Safeguarding and Public protection, together with the six monthly report and the Annual Report for 2018/19.

The following was highlighted from the reports:

- Durham MAPPA were undertaking a serious case review regarding a sexual assault where the perpetrator of the assault was under 18 years old and the Children's Safeguarding Partnership was undertaking a serious case review. It was explained to members of the Committee that the two processes were separate as the children's serious case review would consider the victim, whereas the MAPPA review would look at processes.
- The Trust remained involved in nine serious case reviews for children, five serious adult reviews and five domestic homicide reviews.
- The Safeguarding enquiries at Acomb Garth were still under review with meetings planned.
- The issues regarding Whorlton Hall had been raised by the Safeguarding Adult Board in Durham and there would be a meeting held to review ongoing concerns and to ensure there were no concerns being raised with any other specialist providers in the area.

A Non-Executive Director raised a query around whether there was any impact on the work around safeguarding by the fact that there was no representation on the NY Multi-Agency Safeguarding Team (MAST). It was noted that discussions are underway with York about having a hub-arrangement and the Committee would be kept up to date on any developments.

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

19/81 DRUG AND THERAPEUTICS REPORT AND MEDICINES OPTIMISATION ANNUAL REPORT 2018/19

The Committee received and noted the bi-monthly update on Drugs and Therapeutics together with the Medicines Optimisation Annual Report 2018/19. The report also included a paper detailing new Paris Allergies Module Migration Approach and Clinical Readiness.

The key matters highlighted were:

- The project start date for the electronic prescribing and administration had been postponed to January 2020. This deferred date was agreed at a recent system demonstration between IT, Civica and Pharmacy to avoid competing priorities when implementing CITO and the pharmacy dispensing system.
- The implementation of coded allergies and reactions would begin on Paris later this year and more information would be forthcoming regarding the process of implementation as migrated, uncoded information would need to be verified and coded appropriately.
- The Annual report had been aligned with the strategic priorities and assurance was provided that the Annual Plan for 2019/20 was aligned to the Trust Business Plan and NICE medicines optimisation guidance. Members welcomed the one page summary of the Annual Report for 2018/19.

19/82 RESEARCH GOVERNANCE UPDATE REPORT

The Committee received and noted the six monthly update on Research and Governance.

Professor Reilly highlighted the following:

- The partnership with the University of York collaboration was going very well and there had been further support from EMT to develop new posts in order to sustain the partnership longer term. These posts would be self-funding after three years and would be in place by summer 2019.
- There were a number of new studies that had been opened in the past year and there was an update provided in the report on the results of previous research, a request made by members of QuAC at a previous meeting.

  Following discussion members considered how the Research and Development information fit with the CQC high quality questions and whether the report could be tailored around patient safety aspects of research, ethics and research governance as well as a view on tracking how effective the dissemination of knowledge was from research projects as it was recognised that the implementation of results was sometimes difficult. It was also suggested that research from across the nursing workforce should also be included.

  The Medical Director undertook to discuss this further with Professor Reilly and see if the report could be adapted for the next update.

Action: Dr A Khouja/Prof. Reilly

19/83 EQUALITY, DIVERSITY AND HUMAN RIGHTS REPORT

The Committee received and noted the six monthly update on Equality, Diversity and Human Rights.

The key matters highlighted were:

- The EDHR Steering Group have reviewed information relating to equality, diversity and human rights in line with the Group's terms of reference and agreed KPIs.
- During the second two quarters of 2018/19 the number of incidents of discriminatory behaviour had decreased compared to 2017/18.
- Funding had been secured from the Health Foundation to pilot an approach to embedding a human rights approach to decision making within clinical services. Hartlepool MHSOP team and West Lane Site in Middlesbrough would be the pilot sites.
- There was inconsistency across the Trust around the equality agenda and more work was required to reduce the level of variation across services and localities.
- The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public had marginally reduced from 28% for white staff and 34% for BAME staff in 2017 to 27% and 32% respectively. This linked with metric 5 in the WRES.
  It was noted that it was difficult to tell whether this was statistically significant or a trend and Mrs Jay advised that there were less responses received making analysis more tricky.
- A refreshed Equality, Diversity and Human Rights strategy and scorecard would be completed for autumn 2019.

Following discussion around patient safety data and serious incidents according to ethnicity, Mrs Illingworth undertook to look at this in more detail to see if there needs to be further correlation between people in the broader population and whether there is an under representation.

Action: Mrs J Illingworth/Mrs S Jay

19/84 CLINCIAL AUDIT AND EFFECTIVENESS REPORT

The Committee received and noted the update progress report on the Clinical Audit and Effectiveness.

The key areas highlighted were:

- The year-end clinical audit programme 2018/19 completion status was 94.37% (67 out of 71 audits complete. This was 12% ahead on the previous year's progress.
- The current 2019/20 clinical audit programme is on track with 8 out of 77 complete and a further 38 ongoing (50.65%).

Non-Executive Directors queried the red status of audit number 5432: blanket restrictions and audit number 5634: audit of seclusion and segregation.

(a) With regard to audit 5432 It was noted that this was an ongoing log in each locality of what blanket restrictions were in place and the need for these to be reviewed, refreshed and recorded. This was something that the QuAG groups reviewed on an ongoing basis; however it was clear that there were some improvements to be made.

Heads of Service were developing a process for Directorates to set a minimum frequency for review of blanket restrictions and this would be reflected in the updated Trust policy.

(b) With regard to the audit around seclusion and segregation if was noted that despite the introduction of a specific seclusion module on Paris, improvements were still needed to the documentation.
Modern Matrons for teams involved in this audit would be developing action plans for their areas and these would be approved by the QuAGs.
There would be a further update around Seclusion at the September 2019 QuAC meeting.

Assurance was provided that the Clinical Effectiveness Group continues to monitor relevant clinical audit and effectiveness programmes undertaken within the Trust and facilitates actions to address any potential quality or risk issue around the programme.

19/85 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no matters of exception raised.

19/86 ISSUES DISCUSSED THAT REQUIRE ESCALATION TO THE BOARD

There were no other issues that required escalation.

19/87 ISSUES DISCUSSED THAT MIGHT IMPACT ON THE TRUST'S STRATEGIC OR KEY OPERATIONAL RISKS

There were no issues that might impact on the Trust's risks.

19/88 COMMITTEE EVALUATION

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

19/89 ANY OTHER BUSINESS

There was no other business to discuss.

19/90 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 04 July 2019, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

The meeting concluded at 4.25pm

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BOARD OF DIRECTORS
FOR GENERAL RELEASE

Item No 12

DATE:	**18th July 2019**
TITLE:	**To consider the trust's 2019 Workforce Race Equality Standard and Workforce Disability Equality Standard 2019 submissions and associated action plans.**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Information and Consultation**

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 latest Workforce Race Equality Standard (WRES) information and the first Workforce Disability Equality Standard (WDES) information tell us that more needs to be done to tackle discrimination and other forms of poor behaviour if we are to improve the workplace experiences of staff from these two protected characteristic groups. The proposed actions are unlikely to lead to immediate major changes in staff experience but they will help us to take better informed actions that will be of longer term benefit.

Recommendations:

- To note the contents of the report and to comment accordingly
- To endorse the 2018/19 WRES and WDES action plans.
- To note the 17/18 action plan is complete apart from action 4 for indicator 1 which will be completed in September 2019

MEETING OF:	**Board of Directors**
DATE:	**18th July 2019**
TITLE:	**To consider the trust's 2019 Workforce Race Equality Standard and Workforce Disability Equality Standard 2019 submissions and associated action plans**

1.0 INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide Directors with the trust's latest information sets and associated action plans (2018/19) for the WRES and the WDES for review prior to the ratification of these documents by the Board and subsequent publication.

2.0 BACKGROUND INFORMATION AND CONTEXT:

2.1 The Trust has been required to complete the WRES since June 2016.

2.2 The WDES has been undertaken for the first time this year and is a similar initiative from NHS England aimed to advance equality within the NHS. Similarly to the WRES its development follows research into the experience of disabled staff in the NHS and is mandated in the NHS standard contract. Whilst it is not possible for some indicators to provide comparative data for 17/18, the data for the 17/18 national staff survey results (indicators 4 -9) has been provided.

2.3 The Trust is required to publish its latest WRES information set (2018/19) and associated action plan by 27th September 2019 following ratification by the Board of Directors.

2.4 The trust is required to publish its first Workforce Disability Equality Standard (WDES) information set and action plan (2018/19) by 30th September 2019 following ratification by its Board of Directors.

3.0 KEY ISSUES:

3.1 WRES

3.1.1 This year there has been an improvement in 5 of the 9 indicators, 2 indicators have remained the same and indicators 2 and 4 have worsened.

3.1.2 4% of staff in the Trust are from a BAME background. Indicator 1 gives the percentage of BAME staff in each band. The percentage of BAME in the trust continues to be affected by the large numbers of medical staff who are from BAME backgrounds. There are no BAME staff in Bands 9 and VSM for both

clinical and non-clinical staff. However there has been an increase in the percentage of BAME staff in bands 5, 6 and 7. A key piece of work in 19/20 is to provide further opportunities for BAME staff to progress, this includes delivering a second leadership programme for BAME staff and to develop reciprocal mentoring arrangements for BAME staff and the EMT.

Work will be undertaken to explore having target indicative rates for BAME staff in each band for each locality.

3.1.3 Indicator 2 shows white staff are 1.7 times more likely to be appointed from shortlisting compared to BAME staff, this has increased slightly from 17/18. The BAME staff network has been consulted to review the value based questions used in recruitment. Further work includes reviewing the recruitment and selection procedure and training.

3.1.3 Indicator 3 shows that BAME staff are 1.62 times more likely to enter the formal disciplinary process than white staff. This has decreased significantly from 17/18, when the data showed BAME staff were 2.59 more likely to enter the formal disciplinary process than white staff. This is a positive reduction; however work will continue to monitor disciplinary processes, which includes the EDHR team being consulted in any disciplinary cases that involve BAME staff.

3.1.4 Indicator 4 shows white staff are 1.3 times more likely to access non-mandatory training and CPD compared to BAME staff, this has increased from 17/18. The data has been taken from a response to a question in the staff FFT as the trust has no other way of recording this information.

3.1.5 Indicators 5 and 6 show that BAME staff report experiencing higher levels of harassment, bullying or abuse from staff and from patients, relatives or the public in the last 12 months compared to white staff.

Indicator 8, BAME staff reporting personally experiencing discrimination at work from manager/team leader or other colleagues, has shown an 11% improvement from 17/18; however BAME staff still report higher levels than white staff.
Work includes embedding the procedure for addressing verbal aggression towards staff by patients, carers and relatives and developing a plan for rolling out further training sessions. It has been identified that the role of the Dignity at Work Champions could provide support for staff experiencing discrimination or abuse, efforts to increase the number of these champions will continue in the upcoming year.

3.1.6 91% of white staff believe that the Trust provides equal opportunities for career progression or promotion compared with 81% of BAME staff. This indicator is very similar to 17/18 data and continues to show a significant difference between BAME and white staff. Key work has been identified from the feedback of BAME staff regarding the perceived way secondment/ acting up opportunities are decided and processed in the Trust.

3.2 **WDES**

3.2.1 The data completeness levels on ESR for disability are as follows: 67% not disabled, 5% disabled and 28% undeclared. The high level of incomplete data means that the results for indicators 1 and 3 must be viewed with caution. This compares with 28.4% of staff who responded positively to the national staff survey questions ' Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?' A key piece of work for 19/20 is to improve declaration rates on ESR so that the trust has a more robust understanding of indicators 1 and 3.

Information from the 2011 census states that 38% of the population of the North East and 33% of the population of Yorkshire and Humber report a long standing illness or disability with 20% of the population of the North East and 19% of the population of Yorkshire and Humber reporting a limiting long standing illness or disability.

3.2.2 Disabled staff are 1.7 times more likely to enter formal capability than staff without disabilities. Members of the EDHR team are to review any capability cases involving disabled staff.

3.2.3 Staff with disabilities experience higher levels of harassment/ bullying or abuse from patients, their relatives, other members of the public, managers and other colleagues. It is hoped that the actions described at 3.1.5 above will address this issue

3.2.4 Staff with disabilities are 11% less satisfied with the extent to which the trust values their work compared to staff without disabilities. There are a number of programmes already in place in the trust which it is hoped will address these issues. These include Recovery, Trauma informed Care, Right Care Right Place, Right Staffing, Making a Difference and Digital Transformation

3.2.6 83% of staff with disabilities stated that the trust has made adequate adjustments to enable them to carry out their work. This is a 4% improvement compared to 17/18. The Reasonable adjustments procedure is being reviewed to include improvements to the way specialist IT equipment can be accessed and to develop a portable workplace adjustments plan. Work will be undertaken to publicise this to managers and staff.

4.0 IMPLICATIONS:

4.1 **Compliance with the CQC fundamental Standards:**
It is a requirement of the CQC that the Trust publishes its WRES and WDES and associated action plans.

4.2 **Financial/Value for Money:**

Financial penalties can be incurred for non- compliance with the legislative requirements of the Equality Act. This may result in reputation loss for the Trust. The WRES and WDES support the trust in meeting its duties under the Equality Act.

4.3 **Legal and Constitutional (including the NHS Constitution).**
The Trust is required to publish information demonstrating its compliance with the general public sector duties of the Equality Act 2010. The WRES and WDES documents will meet that legal requirement and as Equality Act compliance is a pre-requisite of Care Quality Commission registration will maintain Trust registration.

4.4 **Equality and Diversity:**
The Trust must demonstrate compliance with statutory and contractual equality requirements. Failure to do so may result in legal action and subsequent financial penalties and damage to the Trust's reputation.

4.5 **Other implications:**
None have been identified.

5.0 RISKS:

5.1 Reputational damage if the experiences of BAME staff and disabled staff do not improve and potentially affecting staff recruitment and retention.

6.0 CONCLUSIONS:

6.1 The latest TEWV WRES information includes both positive and negative changes when comparing 2017/18 information with that of the previous year.

6.2 This is the first time the TEWV WDES information has been published and there are clear differences in experiences and outcomes for disabled staff.

6.3 A number of actions which it is hoped will lessen the differences between BAME and white staff and disabled staff and staff without disabilities have already commenced.

7.0 RECOMMENDATIONS:

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

7.2 To endorse the 2018/19 WRES and WDES action plans.

7.3 To note the 17/18 action plan is complete apart from action 4 for indicator 1 which will be completed in September 2019

David Levy, Director of Human Resources and Organisational Development
Sarah Jay, Equality, Diversity and Human Rights Lead
Lisa Cole, Voluntary Services and EDHR Manager.

Background Papers:

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

WORKFORCE RACE EQUALITY STANDARD

2018/2019

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	1. Background narrative a. Any issues of completeness of data	
	b. Any matters relating to reliability of comparisons with previous years	
	The national staff survey was once again sent to all staff. 73 of those completing it identified as BAME. Last year 123 identified as BAME. The overall Trust response rate reduced to 30.5% in 2018, from 52% in 2017 which may account for the lower numbers of BAME staff responding.	
	2. Total numbers of staff a. Employed within this organisation at the date of the report	
	6679	
	b. Proportion of BME staff employed within this organisation at the date of the report	
	4%	
	3. Self-reporting a. The proportion of total staff who have self-reported their ethnicity	
	99.4%	

	b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity	
	No	
	c. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity	
	The level of self-reporting is very high.	
	4. Workforce data a. What period does the organisation's workforce data refer to?	
	1st April 2018 to 31st March 2019	
	5. Are there any other factors or data which should be taken into consideration in assessing progress?	
	6. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

WORKFORCE RACE EQUALITY STANDARD

	Indicator.	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Target date and person responsible
	For each of these four workforce indicators, compare the data for White and BME staff.					
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Please see appendix 1 at the end of the document for 2019 data.	Please see appendix 2 at the end of the document for 2018 data.	The percentage of BAME in the trust is affected by the large numbers of medical staff who are from BAME backgrounds. There are no BAME staff in Bands 9 and VSM for both clinical and non-clinical staff. For non-clinical staff there are no BAME staff in bands 8c and above. There has been an increase in the percentage of BAME staff in bands 5, 6 and 7.	Carried over from 2017/2018: Invite BAME staff within each locality to meet the chairman. Deliver second BAME leadership programme. Analyse number of BAME staff in post for each band quarterly (percentages and numbers). To develop reciprocal mentoring arrangements for BAME staff and the EMT. Explore having target indicative rates for BAME staff in each band for each	Q2 DL Q2 MB Q3 BVO Q3 MB SJ LC Q3 LC

					locality.	
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	White staff are 1.7 times more likely to be appointed from shortlisting compared to BAME staff.	White staff are 1.6 times more likely to be appointed from shortlisting compared to BAME staff.	There has been a slight increase in this indicator. Recalculated in a different way,	Review the recruitment and selection procedure. Include information about positive action and how staff should implement this. Review the recruitment and selection training. Consider if the training should be mandatory and how it should be delivered. Explore how feasible it will be to trial having BAME staff on a selection of interview panels. Review value based recruitment questions. Consultation with BAME staff on the new proposed questions.	Q3 BVO Q3 BVO, LC Q4 BVO Q2 AC
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from last two year rolling average of the current year and the	BAME staff are 1.62 times more likely to enter the formal disciplinary process than white staff.	BAME staff are 2.59 times more likely to enter the formal disciplinary process than white staff.	BAME staff are more likely to enter the disciplinary process than white staff. This indicator has decreased during the past year.	HR to involve the Equality & Diversity and Human Rights team when a BAME staff member is potentially entering the formal disciplinary process. Explore disciplinary decision making tools from	Q2 BVO SJ LC BS Q3 LC

	previous year.				other Trusts. Analyse capability information for BAME staff. Explore the feasibility of having focus groups for BAME staff that have gone through disciplinary procedures.	 LC Q2 Q3 BVO
4.	Relative likelihood of staff accessing non-mandatory training and CPD.	White staff are 1.31 times more likely to access non-mandatory training and CPD compared to BAME staff.	White staff are 1.20 more likely to access non- mandatory training and CPD compared to BAME staff.	As in last year the information for this indicator has been taken from a response to a question in the staff FFT as the trust has no other way of recording this information. The results show that white staff are more likely to access non- mandatory training and CPD compared to BAME staff	Deliver second BAME leadership programme. To develop reciprocal mentoring arrangements for BAME staff and the EMT.	Q2 MB Q3 MB SJ LC
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, <u>compare the outcomes of the responses for White and BAME staff</u>.					
5.	KF 25. Percentage of staff experiencing harassment,	White: 27% BAME: 32%	White: 28% BAME: 34%	The difference between the experience of white	Embedding the procedure for addressing verbal	Q4 SJ

	bullying or abuse from patients, relatives or the public in last 12 months.			and BAME staff has improved and there has been a 2% reduction in 2018. However the trust is still concerned at the high levels of all staff who experience harassment, bullying or abuse from patients, relatives or the public	aggression towards staff by patients, carers and relatives. Develop a plan for rolling out further training sessions. De-escalation training to be delivered to additional 500 staff. Explore developing a campaign regarding tackling abuse this will include working with the police services.	LC KB Q4 KB Q4 SJ LC Comms LP
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	White: 20% BAME: 24%	White: 19% BAME: 29%	The gap between BAME and White staff's experience of bullying, harassment and abuse has decreased from 2017; however there is still a 4% difference.	Undertake work to increase the amount of dignity at work champions within the organisation to reflect 10% of number of teams (approx. 30-40 people) and ensure geographical spread of the champions. Promoting and relaunching the dignity at work champion role. Evaluate the current dignity at work champions, what are the issues being raised?	Q3 BVO Q3 BVO Q2 BVO

					Promote the bullying and harassment procedure. Explore if crowdsourcing can be used to explore staffs experiences of harassment, bullying or abuse. Analyse cases that involve BAME staff experiencing bullying and harassment from other staff (disciplinary cases, grievances).	Q2 BVO Q4 DL Q3 BVO
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion.	White: 91% BAME: 81%	White: 91% BAME: 80%	The percentage remains similar from 2017; however they still continues to be a 10% difference in how white staff report compared to BAME.	Analyse exit interview information to see if identify whether any race related issues are raised. Review how temporary appointments and secondments are identified and appointed to. Promote BAME Leadership Programme.	Q3 BVO Q3 BVO Q4 MB
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the	White: 5% BAME: 7%	White: 6% BAME: 18%	BAME staff are more likely to have experienced discrimination at work	Actions from indicator 6 Facilitate mediation	 Q3

	following? b) Manager/team leader or other colleagues.			from manager/ team leader or other colleagues. However there has been an 11% improvement from 2017.	network events to share experiences (two per year).	MB
	Board representation indicator: For this indicator, compare the difference for White and BME staff.					
9.	Percentage difference between the organisations' Board voting, non-voting membership and NEDs and its overall BAME workforce.	Percentage difference between the Board voting membership and its overall BAME workforce was +4% The Percentage difference between the Board's non- voting membership and NEDs and its overall BAME workforce was --4%	Percentage difference between the Board voting membership and its overall BAME workforce was +4% The Percentage difference between the Board's non- voting membership and NEDs and its overall BAME workforce was --4%	There have been changes to the voting and executive membership of the Board.	To design and implement a process whereby Non-Executive Directors mentor Trust BAME staff who are identified through talent management processes as having the potential to take up an executive role within the next three years. Shadow board promote to BAME staff.	Q3 Chairman Q4 MB

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

APPENDIX 1

DETAILED STAFF BREAKDOWN RACE 2019

Band	Clinical	Non- Clinical
	BAME	BAME
1-4	2%	1%
5-7	3.4%	2%
8a-8b	2.9%	3%
8c-8d	1%	0%
9	0%	0%
VSM	0%	0%
Of which Medical and Dental		
All medics	40.8%	N/A

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

APPENDIX 2

DETAILED STAFF BREAKDOWN RACE 2018

Band	Clinical	Non- Clinical
	BAME	BAME
1	0%	2%
2	9%	2%
3	2%	1%
4	2%	1%
5	5%	6%
6	2%	1%
7	1%	1%
8a	1%	4%
8b	0%	0%
8c	1%	0%
8d	0%	0%
9	0%	0%
VSM	0%	0%
Of which Medical and Dental		
Consultants	37%	0%
Senior Medical Manager	33%	0%
Non- consultant career grade	48%	0%
Trainee grade	40%	0%
Total (including medics)	4%	1%
Total excluding medics	2%	1%

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

WORKFORCE DISABILITY EQUALITY STANDARD

2018/2019

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	1. Background narrative a. Any issues of completeness of data	
	b. Any matters relating to reliability of comparisons with previous years	
	2. Total numbers of staff a. Employed within this organisation at the date of the report	
	6779	
	b. Proportion of disabled staff employed within this organisation at the date of the report	
	5%	
	3. Self-reporting a. The proportion of total staff who have self-reported their disability	
	72%	

	b. Have any steps been taken in the last reporting period to improve the level of self-reporting by disability	
	No	
	c. Are any steps planned during the current reporting period to improve the level of self-reporting by disability	
	4. Workforce data a. What period does the organisation's workforce data refer to?	
	1st April 2018 to 31st March 2019	
	5. Are there any other factors or data which should be taken into consideration in assessing progress?	
	6. Organisations should produce a detailed WDES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WDES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WDES Action Plan or provide a link to it.	

Tees, Esk and Wear Valleys NHS Foundation Trust

WORKFORCE DISABILITY EQUALITY STANDARD

	Indicator.	**Data for reporting year**	**Data for previous year**	**Narrative – the implications of the data and any additional background explanatory narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective**	**Target date and person responsible**
	For each of these four workforce indicators, compare the data for disabled and non-disabled staff.					
1	% of staff in each of the AfC pay bands or medical and dental subgroups and VSM (excluding executive board members) compared with the % of staff in the overall workforce.	Please see appendix 1 at the end of the document for 2019 data.	N/A	Based on the information we have there seems to be a representative distribution of disabled staff up to but not including band 9 pay grades or medics. However there is circa 30% non- disclosure.	To work with the disability subgroup of the DEG to improve self-declaration rates. Advice will be sought from the BDF.	Q2 AC AFC posts
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	Non-disabled staff are 1.23 times more likely to be appointed from shortlisting compared to disabled staff.	N/A	All candidates are eligible to be shortlisted under the disability confident standard when they meet the minimum standards in the person specification. Work is ongoing , though not strictly consistent with this indicator to understand how many disabled people who are guaranteed an	To monitor on a monthly basis how many disabled people who were shortlisted under the disability confident scheme criteria were appointed. If necessary to work with services to address any issues about recruitment decisions. Explore the possible option to involve disabled	Q3 LM Q4 LM

				interview under this scheme are actually interviewed	staff on a selection panel of interviews on a trial basis. To review the value based recruitment process. Consult with disabled staff on the new proposed questions and make recommendations to the right staffing programme board. .	 Q2 LH
3.	Relative likelihood of staff entering the formal capability process, as measured by entry into a formal process. This indicator will be based on data from a two year rolling average of the current year and the previous year.	Disabled staff are 1.7 times more likely to enter formal capability than non-disabled staff.	N/A		Review capability cases for staff with disabilities and identify if there are common themes. Feasibility of focus groups for staff that have gone through capability procedures to gain an understanding of lessons learnt. HR operations to update ESR when they are made aware of staff that have a disability via the capability and sickness processes. After Q2 this will become business as usual.	Q3 BVO Q3 BVO Q2 BVO
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey					

	indicators, compare the outcomes of the responses for disabled and non-disabled staff.					
4.	Percentage of staff experiencing harassment/bullying or abuse from: i. Patients/service users, their relatives or other members of the public ii. Managers iii. Other colleagues	Disabled 32% Non-disabled 25% Disabled 15% Non-disabled 8% Disabled 20% Non-disabled 14%	Disabled 34% Non-disabled 26% Disabled 12% Non-disabled 5% Disabled 28% Non-disabled 17%		Embed the 'addressing verbal abuse' procedure via the delivery of training trust wide as part of a campaign to promote the non-tolerance of abuse of staff at work. By 31st March 2020 using the coaching approach to work with the DEG to identify whether underlying traits displayed by disabled staff invite harassment and bullying behaviours to take place against them. If appropriate to make any associated recommendations to the EDHR steering group in the first instance.	*Q4* LC/SJ/AH, PAT team *Q4* AC and DEG
5.	Percentage believing that Trust provides equal opportunities for career progression or promotion.	Disabled 87% Non-disabled 92%	Disabled 86% Non-disabled 91%			
6.	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled 22.5% Non-disabled 17%	Disabled 24% Non-disabled 17%			

7.	Percentage of staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled 46% Non-disabled 57%	Disabled 44% Non-disabled 54%	It is understood that the following Trust wide programmes are already in place which amongst other things aim to address item 7: . Recovery Trauma informed Care Right Care Right Place Right Staffing Making a Difference Digital Transformation		
8.	Percentage of staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Disabled 83%	Disabled 79%		The Reasonable adjustments policy is being reviewed to take into account feedback from the BDF.. Improvements have been made to the process for accessing specialist IT equipment in a timely manner. Work will be undertaken to monitor equipment / training put in place linked directly with reasonable adjustments. The procedure contains a workplace adjustment plan which is expected to be portable.	Q2 HC Q2 -4 HC

					To communicate the updated guidance document to ensure that staff and managers are aware of this and use it appropriately.	Q3 -4 HC
9.	a) The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation. b) Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard? Yes or No Response to b)	Disabled 6.9 Non-disabled 7.4	Disabled 3.7 Non-disabled 3.8		To review the scope and effectiveness of the Disability subgroup of the Diversity Engagement Group with the aim of increasing the level of participation of disabled staff in the work of the group. Diversity Group meetings Consideration will be given to the use of SKYPE and using crowdsourcing as a tool to engage directly with those staff that have a disability. Work with the Business Disability Forum to identify related best practice within other organisations and consider adoption of these practices within TEWV.	Q3 HC. AC. DEG
10.	Percentage difference between the organisations' Board voting, non-voting membership and NEDs and its overall disabled workforce.	Percentage difference between the Board voting membership and its overall disabled	Percentage difference between the Board voting membership and its overall disabled workforce is		Please see actions for indicator 1.	Q2

		workforce is -5%.	-8%			

APPENDIX 1

DETAILED STAFF BREAKDOWN DISABILITY 2019

Band	Clinical			Non-clinical		
	DISABLED	NON-DISABLED	NOT DECLARED	DISABLED	NON-DISABLED	NOT DECLARED
1 - 4	6%	57%	37%	5%	64%	31%
5 - 7	6%	72%	22%	6%	72%	22%
8a – 8b	4%	73%	23%	3%	57%	40%
8c – 8d	4%	59%	37%	6%	44%	50%
9	0%	50%	50%	0%	50%	50%

VSM	0%	0%	0%	0%	40%	60%
Of which Medical and Dental						
All medics	2%	80%	18%			

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

WORKFORCE RACE EQUALITY STANDARD

2017/2018

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	1. Background narrative a. Any issues of completeness of data	
	In relation to Indicator 4 the relative likelihood of BAME staff accessing non-mandatory training and CPD compared to White staff. The Trust doesn't have a process for monitoring requests or approvals for non- mandatory training at present. However the Staff Friends and Family Test does ask a question around access to non-mandatory training and this can be broken down into white and BAME staff for the purpose of this indicator.	
	b. Any matters relating to reliability of comparisons with previous years	
	The national staff survey was once again sent to all staff this year. 123 of those completing it identified as BAME. Last year 101 identified as BAME therefore the increase year on year gives the Trust greater confidence in the results.	
	2. Total numbers of staff a. Employed within this organisation at the date of the report	
	6512	
	b. Proportion of BME staff employed within this organisation at the date of the report	
	4%	
	3. Self-reporting a. The proportion of total staff who have self-reported their ethnicity	
	99.4%	

	b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity	
	No	
	c. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity	
	The level of self-reporting is very high.	
	4. Workforce data a. What period does the organisation's workforce data refer to?	
	1st April 2017 to 31st March 2018	
	5. Are there any other factors or data which should be taken into consideration in assessing progress?	
	6. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

WORKFORCE RACE EQUALITY STANDARD

	Indicator.	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Target date and person responsible
	For each of these four workforce indicators, compare the data for White and BME staff.					
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	detailed breakdown of staff 2018.docx	Detailed staff breakdown Race2.do	The percentage of BAME in the trust is affected by the large numbers of medical staff who are from BAME backgrounds. There are no BAME staff in Bands 8b, 8d and 9 for both clinical and non-clinical staff. For non- clinical staff there are no BAME staff in bands 8b and above. There has been an increase in the percentage of BAME staff in bands 5, 6 and 7.	1. To evaluate and subject to the outcome to continue to run the BAME Leadership Programme for Bands 5 – 7. 2. Please refer to the work that is to be done on improving likelihood of recruitment. 3. To publicise and raise awareness of senior BAME leaders within TEWV. 4. Invite BAME staff within each locality to meet the chairman.	**Q 2 and Q4** **Q2, Q3, Q4** Q4 (to be carried over to 2018/2019 action plan due to the change of chairman)
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	White staff are 1.6 times more likely to be appointed from	White staff are 1.32 times more likely to be appointed from	There has been a slight deterioration in this indicator.	1. Batch recruitment seems to result in a higher likelihood of BAME	**Q1-Q4**

		shortlisting compared to BAME staff.	shortlisting compared to BAME staff.	A review of recruitment decisions where shortlisted BAME job applicants were not appointed to posts during a three month period has been undertaken. There seems to be a disparity in the likelihood of BAME staff obtaining secondment/acting up opportunities.	staff being appointed so it is suggested that this is used wherever possible. 2. It is suggested that work be undertaken with BAME staff at bands 7 and 8a to understand why they are not progressing to higher bands. 3. Formalising the acting up/secondment may encourage more staff from the BAME community to apply. The procedure could also ensure that an appropriate closing date is applied to each post as this again may encourage more BAME staff to apply and remove the stigma that 'the appointing manager already knows who they wish to appoint' which is usually attached with posts with shorter deadlines. 4. To review the content of recruitment and selection training to ensure it addresses issues of bias. 5. To review values based recruitment questions and to publicise feedback that 'wildcard'	**Q3** **Q4** **Q3** **Q3**

					questions are sometimes being asked inappropriately. To strengthen guidance on 'wildcard' questions. To consider randomly sampling interviews and to introduce questions that highlight bias during interview. 6. To publish information about recruitment of internal and externally appointed candidates and communicate the issue of perceived bias throughout the trust.	**Q4**
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from ta two year rolling average of the current year and the previous year.	BAME staff are 2.59 times more likely to enter the formal disciplinary process than white staff.	BAME staff are 2.08 times more likely to enter the disciplinary process than white staff.	BAME staff are more likely to enter the disciplinary process than white staff. This indicator has worsened during the past year.	1. To examine in detail the context and reasons for disciplinaries undertaken on BAME staff and in particular any processes that have gone on to address behaviour earlier. .	**Q3 & Q4**
4.	Relative likelihood of staff accessing non-mandatory training and CPD.	White staff are 1.20 more likely to access non- mandatory training and CPD compared to BAME staff.	White staff are 1.15 times more likely to access non-mandatory training and CPD compared to BAME staff	This year information for this indicator has been taken from a response to a question in the staff FFT as the trust has no other way of recording this information at	No action is to be taken on this indicator	

				present. The results show that white staff are slightly more likely to access non- mandatory training and CPD compared to BAME staff		
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.					
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White: 28% BAME: 34%	White: 28% BAME: 37%	The difference between the experience of white and BAME staff has improved and there has been a 3% reduction in 2017. This difference is mirrored in incidents recorded on DATIX. The trust is concerned at the high levels of all staff who experience harassment, bullying or abuse from patients, relatives or the public	1. The Trust is developing a procedure for addressing verbal abuse of staff by patients and for supporting staff. Extensive consultation has been undertaken and a draft guidance document is to go to BOD in July 2018. 2. This will be followed up by training for managers in how to implement the procedure. 3. A statement outlining the trust's position on verbal abuse of staff is being developed with the support of the chairman and CEO and once completed this will be displayed throughout the trust.	**Q2** **Q4** **Q3**

					.	
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	White: 19% BAME: 29%	White: 17% BAME: 19%	The gap between BAME and White staff's experience of bullying, harassment and abuse has unfortunately increased by 10%. The experiences of White staff have also decreased but by a lesser figure.	1. Develop a Bullying and Harassment Resolution Policy. This is underway and will be completed July 2018. 2. BAME members of staff will be recruited as dignity at work champions. 3. Offer more 'mediation' training to staff and encourage BAME to be involved.	**Q3** **Q4**
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion.	White: 91% BAME: 80%	White: 94% BAME: 94%	There is a significant deterioration in the reported experience of BAME staff compared to 2016 and against the experiences of white staff.	1.To raise awareness of the tie breaker provision of the Equality Act and to include this in recruitment training. 2.To trial the question within the Staff FFT. 3.To explore National Staff Survey results to identify hotspots. (Please also see actions for metrics 1, 2 and 3)	**Q2** **Q4** **Q4**
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	White: 6% BAME: 18%	White: 5% BAME: 3%	BAME staff are more likely to have experienced discrimination at work from manager/ team leader or other colleagues. The results for BAME staff in relation to this indicator	Please refer to actions for metric 6.	

				have worsened in the last year		
	Board representation indicator: For this indicator, compare the difference for White and BME staff.					
9.	Percentage difference between the organisations' Board voting, non-voting membership and NEDs and its overall BAME workforce.	Percentage difference between the Board voting membership and its overall BAME workforce is +8.5% The Percentage difference between the Board's non- voting membership and NEDs and its overall BAME workforce is -4%	Percentage difference between the organisations' BAME Board voting membership, non-voting membership and NEDs and its overall BAME workforce is -4.0%	There have been changes to the voting and executive membership of the Board.	No action is to be taken on this indicator.	

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 13

FOR GENERAL RELEASE
TRUST BOARD

DATE:	**18 July 2019**
TITLE:	**Progress report on the development of a community safe staffing dashboard**
REPORT OF:	**Elizabeth Moody**
REPORT FOR:	**Information**

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

Executive Summary:

The report presents a set of metrics to be considered in the development of a community safe staffing dashboard which will serve as an early warning score or "team temperature" gauge, thus supporting managers with monitoring and oversight of the community team and enabling timely and proactive interventions and support.

The key metrics are themed to enable a RAG rating for each of the areas below:

1. Leadership
2. Service user feedback/outcomes
3. Service user demand
4. Staffing indicators
5. Workload impacts to staff
6. Workforce shortfall

Developing a community safe staffing dashboard at team level will support in achieving compliance with CQC well led framework requirements and NQB and NHSI recommendations. It will support clinical team managers and operational managers to proactively identify teams where additional support and focus may be required, in addition to providing assurance to the Board that robust and effective early warning indicators are in place to ensure staff and patient safety.

Recommendations:

For the Board to review the report and recommend any further actions to consider for the development of a community staffing dashboard.

Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF:	**Trust Board**
DATE:	**18 July 2019**
TITLE:	**Community Safe Staffing Dashboard**

1. INTRODUCTION & PURPOSE:

The purpose of this report is to present a set of metrics to be considered in the development of a community safe staffing dashboard which will serve as an early warning score or "team temperature" gauge, thus supporting managers with monitoring and oversight of the community team and enabling timely and proactive interventions and support.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1. The National Quality Board (NQB) have defined a set of guidelines for mental health (NQB, 2018)[1] to support the recommendations set out in Francis Report (2013) and Hard Truths Report (2014) by providing a set of expectations to deliver "safe, effective, caring, responsive and well led care". It makes the expectation clear that all NHS organisations need to have robust escalation processes, stating that there should be routine daily assessments of staffing requirements, with a protocol for escalating concerns regarding the safety and effectiveness to a senior level.

2.2. The trusts community safe staffing escalation procedure outlines the actions to be taken if staffing shortfalls are evident however this is a reactive process and NQB guidelines recommend that trusts organise a dashboard or balanced scorecard 'view' at three levels; one of these levels being at team level – this provides clinical managers with a local view of staffing levels and indicators at single team level in order to proactively manage staffing resources..

2.3. The expectations of clinical and managerial leaders is to use professional judgement in conjunction with local quality dashboard data and ensure the team has plans to use the workforce flexibly to respond to temporary, unknown and unplanned variations in service need and the impacts to sustainable, safe, effective, caring, responsive and well-led care.

2.4. Developing Workforce Safeguards (NHSI, 2018) also states that Trust Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard.

3. KEY ISSUES

3.1. Currently the Trust has a staffing escalation procedure in place which relies upon the leadership team to follow and report accordingly; this defines a set of triggers and red flags relating to an acute or sustained staffing shortfall in a reactive manner.

3.2. We do not currently have a set of key community metrics provided in a simplified dashboard view format that supplements the escalation procedure, and also provides operational management a visual display of their teams which can support early intervention and support as necessary.

3.3. The aim is to provide a standard set of key performance indicators for community teams to convey an early warning sign for teams potentially requiring support. This will be used in conjunction and support the community safe staffing escalation standard operating procedure.

3.4. Operational and clinical staff participating in the recent Kaizen events for safe staffing establishment reviews have developed a data set of key indicators to be used for the 6 monthly formal review process in support of professional judgement discussions. It has been indicated that trend data would have increased benefit in understanding the needs of the team rather than a snapshot view of team data.

3.5. The model hospital reports on national data for community teams and allows for peer review and benchmarking; this was considered in conjunction with the staffing establishment review data set to provide a recommendation for the key data elements.

3.6. It is suggested each dashboard item may consist of more than one data element which can be presented as a set of trend values across a 6 month period. This may then determine a RAG rated outcome dependent upon the trend values. The data elements for each dashboard item are themed as below and detailed in Table 1:

1. Leadership
2. Service user feedback/outcomes
3. Service user demand
4. Staffing indicators
5. Workload impacts to staff
6. Workforce shortfall

Dash Board Item	Data elements	Comment
1	Leadership team availability	Team manager; Advanced practitioner; Consultant. Unavailable > 2 weeks without mitigation action plan
2	Complaints & SI's; patient FFT	Items to indicate impact on service users of sickness rates, work load, long term effects on staff wellbeing and morale, patient safety.
3	Referral rates, unallocated cases, waiters	Shows Items also available on Model Hospital- • Contact hours per clinical FTE per day; • % clinical contact time; • Referrals per clinical FTE • % of patient caseload without care contact; • Days between referral to 1st contact to 2nd contact • Contacts per clinical FTE per day;
4	Appraisals; clinical supervision; statutory and mandatory training; HR Issues; staff FFT	Performance measures indicating impacts to workload competency and safety.
5	Time owing; annual leave carry over; length of daily working hours	Items to indicate potential additional workload requirements on the team
6	Sickness; vacancies; bank/agency usage	Staffing shortages and temporary staffing solutions

Table 1: Data Elements per dashboard

3.7. The format of the dashboard items are yet to be developed with clinical and operational teams.

3.8. It is anticipated that the dashboard will be made available on IIC at a future point, but it may be required to be distributed via Excel spreadsheet for an interim period pending availability on the schedule on the IIC project plan.

3.9. The introduction of community e-rosters is being explored which may simplify data collection and reduce the burden of data collection.

3.10. Data elements will be subsequently reviewed to evaluate the required level of assurance is met.

4. IMPLICATIONS:

4.1. **Compliance with the CQC Fundamental Standards**:

Working in line with standards outlined within 'Developing Workforce Safeguards' and the NQB guidelines will enhance compliance with the CQC well led framework.

4.2. **Financial/Value for Money**:

Greater management of resources could impact on agency use and early intervention within teams experiencing difficulty could impact on staff morale and sickness therefore reducing costs.

4.3. **Legal and Constitutional (including the NHS Constitution)**:

None identified.

4.4. **Equality and Diversity**:

None identified.

5. RISKS:

- e-Rosters for community teams will simplify the data collection for key items - workforce data seen in dashboard items 1, 5 & 6 in Table 1. If community e-Rosters are not available the burden of data collection will fall to the clinical teams manually providing the data returns, and to ensure it is provided in time to produce the community dashboard in a timely manner.
- There will be a requirement to manually retrieve Model Hospital data for review and upload to the dashboard. This may be mitigated by adjusting the frequency to quarterly data collection of Model Hospital data elements.
- Metrics may not wholly provide the required level of assurance and may need to be reviewed to deliver this.
- IIC team delivery of the dashboard indicators may be impacted by current workload and resource capacity.

6. CONCLUSIONS:

Developing a community safe staffing dashboard at team level will support in achieving compliance with CQC well led framework requirements and NQB and NHSI recommendations. It will support clinical team managers and operational managers to proactively identify teams where additional support and focus may be required, in addition to providing assurance to the Board that robust and effective early warning indicators are in place to ensure staff and patient safety.

7. RECOMMENDATIONS:

For the Board to review the report and recommend any further actions to consider for the development of a community staffing dashboard.

Joe Bergin
Right Staffing Senior Programme Manager

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**18 July 2019**
TITLE:	**Triangle of Care stage 2 submission**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance / Approval**

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

Executive Summary:

The purpose of this report is to provide assurance that the aims and objectives of the Triangle of Care (ToC) have been met during the Stage 2 of implementation and to seek approval before submission to the Carers Trust. The aim is to raise the profile of carers to ensure they are involved and supported as partners in care as part of a patient's journey to recovery.

ToC membership involves Trust staff working with carers and carer organisations to complete and submit self-assessment tools based on six national key standards to the Carers Trust.

During Stage 2, community teams are required to use a traffic light rating system to mark themselves Red, Amber or Green for each of the standards. As in Stage 1 (with wards and crisis teams) community teams are asked to be honest and have been assured this is not a performance measure, rather an opportunity to assess if improvements are required and take action as required.

This report outlines the achievements of implementing ToC in the Trust so far, including the background in Stage 1 and key findings from Stage 2 community self-assessments and identifies the next steps for embedding carer support in the Trust.

Recommendations:

- The Board of Directors is asked to recommend the submission of the community team self-assessments and this report to the Carers Trust and panel based on the findings of this report.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**11 July 2019**
TITLE:	**Triangle of Care stage 2 submission**

1. INTRODUCTION & PURPOSE:

1.1.1 The purpose of the report is to provide assurance that the aims and objectives of Triangle of Care (ToC) stage 2 have been met prior to submission of a report to the Carers Trust.

1.2 The aims are to raise the profile of carers to ensure they are involved and supported as partners in care as part of a patient's journey to recovery. This report will outline the steps that have been taken to date and further work that will be required.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 In March 2014 the Trust Board of Directors approved an updated Carer Support Strategy (2014 – 2017) developed and written with the help of carers and trust Governors. It included a specific recommendation from a serious case review to implement the principles of the Triangle of Care (ToC).

2.2 In 2014/15 a local CQUIN included key elements from the Carer Support Strategy's implementation plan and the trust applied to the Carers Trust for ToC membership. 25 teams were engaged and some carer awareness training was delivered however during this period, self-assessments were not submitted to the Carers Trust and ToC membership ended in March 2015 when the CQUIN was completed.

2.3 In 2016 the trust agreed ToC membership as a business priority through the Project Management Framework and in September 2017 TEWV submitted 73 self-assessments and a report to the Carers Trust. In March 2018 following a presentation to the Regional ToC Steering group the trust was awarded Stage 1 of ToC membership. In 2018 and 2019, community teams have been completing self-assessments as part of the requirements of Stage 2.

3. KEY ISSUES:

3.1 A well-attended monthly steering group monitors and supports the implementation of ToC. The group is chaired by the Director of Nursing and Governance and membership includes Heads of Nursing (HON), a trust Governor, carers and carer organisation representatives, as well as service user experts by experience.

3.2 HON's have taken the lead for implementation in the localities and forensic directorate using a variety of approaches to co-ordinate the completion of self-assessments. Evidence of carer involvement is an important part of the

submission and is included in the report, with examples given of this taking place at established meetings, through discussions with individual carers, working with local carer organisations, visiting wards and using a carer validation questionnaire. The trust's established carer feedback survey has also been included with 5,072 carers completed surveys from the 97 teams involved in the submission. 91% (3,329 carers) responded positively to the questions, "Do you feel actively involved in decisions about care and treatment of the person you care for."

3.3 **Standard 4** of ToC requires teams to allocate a member(s) of staff as carer champion(s)/carer links with a role description approved by the steering group. This role involves providing guidance and support to staff in relation to carer issues and ensuring carer support information is available and kept up to date. All teams have identified carer champions. Carer champions have received regular communication bulletin updates for advice and support with links to the trust's 'T' Drive to locate key documents relating to carer support and ToC.

3.4 Supporting carers is the responsibility of all clinical staff and **Standard 2** requires that all staff should receive carer awareness training. Carer awareness training was established in Stage 1 and has continued throughout Stage 2. In total, 1,266 staff have received face to face training and 447 have registered for online carer awareness training. The training has been co-delivered by TEWV with carers and local carer organisations from across the trust area.

3.5 97 community team self-assessments have been completed with approval by QuAG's. The results of 95 self-assessments on each of the criteria are included in this report by locality/service using the traffic light system. Where teams scored Red or Amber, action plans are expected and will be monitored for completion.

3.7 In addition to individual service/teams action plans, there are some common themes identified and include those identified at the carers conference held in May 2019. A trust wide action plan will be followed through the ToC steering group. Actions include follow up to see that Paris (identified in Stage 1) has been updated to meet requirements for recording carer information as part of ToC and CPA to give clinical staff consistency and ease of access. Further carer awareness training for staff will include updating and assurance in relation to confidentiality issues and sharing of information. Carer support information will be updated including website information.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

This project supports the CQC Fundamental Standards as supporting carers through initiatives such as the Triangle of Care is an investment in safety, quality and continuity of care.

4.2 Financial/Value for Money:

ToC is resourced with a 0.6 WTE Band 6 Officer to co-ordinate the continuing requirements of membership and carer support development. Training to date has been provided free of charge by the carer organisations however this may change as the trust continues to request organisations to provide training.

4.3 Legal and Constitutional (including the NHS Constitution):

There are no legal and constitution implications with this project.

4.4 Equality and Diversity:

The ToC aims to support carers from all backgrounds across all standards and Standard 5 specifically refers to information which ensures the cultural and language needs of carers are addressed in the preparation of an information pack for carers. This is being addressed as part of action plans.

4.5 Other implications:

There are no other implications identified as part of ToC.

5. RISKS:

A number of improvements have been identified both at team and Trust level, a challenge for services will be to maintain momentum with implementation of their action plans with all the other competing priorities. There is a risk that staff will have difficulty meeting the targets for training and carer awareness if they are not able to attend training and carer champion meetings. The continuation of the ToC steering group and dedicated carer support leadership will help to mitigate identified risks.

6. CONCLUSIONS:

Overall there has been success with implementation of ToC to date, by using the ToC self- assessment tool, the community teams have taken time out to consider how they support and involve carers on a day to day basis. Staff attending training have heard first-hand how they can help carers. Carers

have been asked for their opinions and involved in different ways throughout this process and will continue to be an integral part of ToC.

7. RECOMMENDATIONS:

7.1 The Board of Directors are asked to recommend the submission of the community team self-assessments and report to the Carers Trust based on the findings of this report and the continuation of ToC across services.

Elizabeth Moody
Director of Nursing and Governance

Background Papers:

TEWV Carer Support Strategy (2014 – 2017)

Triangle of Care Membership Scheme Submission Report – July 2019

Organisation Overview

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) provides a range of mental health, learning disability and eating disorder services for the people living in County Durham and Darlington, the Tees Valley, York and most of North Yorkshire.

With over 6,500 staff and an annual operating income of over £300 million we deliver our services by working in partnership with local authorities, clinical commissioning groups, a wide range of other providers including voluntary organisations and the private sector, as well as service users, their carers and the public.

Our community services are spread over many different sites, managed in three operational directorates referred to as localities, (Durham and Darlington, Teesside, North Yorkshire and York) and we have a forensic directorate).

The trust's mission is:

- To improve people's lives by minimising the impact of mental ill-health or a learning disability.

The Trust's vision is:

- To be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations.

Strategic goals

The mission and vision drives our strategic and operational plans through five strategic goals – these are the things that drive our priorities:-

1) To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing
2) To continuously improve the quality and value of our work
3) To recruit, develop and retain a skilled, compassionate and motivated workforce
4) To have effective partnerships with local, national and international organisations for the benefit of the communities we serve
5) To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.

TEWV's Board approved a Quality Strategy 2017- 2020 in December 2016 which sets out our ambition for quality which is to ensure safe, patient centred and effective

high quality care and treatment. There are three goals, each with a range of measurable objectives:

1) Patients, carers and staff will feel listened to and heard, engaged and empowered and treated with kindness, respect and dignity;
2) We will enhance safety and minimise harm;
3) We will support people to achieve personal recovery as reported by patients, carers and clinicians.

The trust has been committed to supporting and involving carers for a number of years with an Involvement and Engagement Strategy and a Carers Strategy written with the help of carers and Governors in 2011 and updated in 2014. Membership of Triangle of Care (ToC) provides a structured framework for carer support, ensuring consistency and equity for carers across the trust, measuring against the six key standards. ToC membership ensures the profile and awareness of carers is raised across services with areas for improvement and action identified and monitored.

Implementation Process

The implementation of ToC in TEWV was approved as a business priority in 2016 and a part-time project lead was appointed.

Stage 1 implementation (Inpatient and Crisis teams)

The Carers Trust gave a one year timescale for submission of a report and completed self-assessments for inpatient and crisis teams. TEWV completed this in the following ways:-

- A regular ToC steering group meeting to oversee and monitor progression, led by the Director of Nursing and Governance and Heads of Nursing (localities and forensic services). Attendees include carers and carer organisations representatives and service user experts by experience
- Heads of Nursing led the process for ensuring self-assessments were completed using their communication networks, including local ToC meetings
- A database of carer champions in teams was established to send relevant information to champions and team managers
- 15 carer awareness training sessions took place aimed at carer champion and also attended by other interested clinical staff. The sessions were co-delivered with TEWV, carer organisations and carers working together. The organisations who took part in the training in their respective areas included:-

  Durham and Darlington County Carer Support
  Middlesbrough Mind
  Carers Together, Middlesbrough and Redcar
  Harrogate Carers Centre
  York Carers Centre

Scarborough Carer Support with Trust Governor (carer)

- At the time of submission of stage 1, a total of 461 staff had received carer awareness training between 2013 and 15th September 2017.

Completion of Stage 1

In September 2017, TEWV submitted to the Carers Trust, self-assessments from 73 ward and crisis teams with a report which included an analysis of the self-assessments. A presentation was given to the regional ToC group in March 2018 and the Carers Trust awarded stage 1 of ToC membership to TEWV.

Stage 2 (community services)

TEWV has remained committed to implementing ToC and improving carer engagement and support as follows:-

- Leadership continues from the Director of Nursing and Governance and Heads of Nursing including their regular attendance at the ToC steering group to monitor and oversee implementation of ToC.

- Following a request at the steering group for an update on progress in the wards and crisis teams with implementing ToC, an action plan presentation was given at a steering group meeting in February 2019.

- Communication with carer champions and team managers continued through the database and regular bulletins.

- Delivery of carer awareness training continued in partnership with carers and carer organisations. In addition to those organisations involved in stage 1, Hambleton & Richmondshire carers centre delivered training in their area. 62 face to face training sessions were delivered between October 2017 and April 2019 across all areas of the trust to 805 clinical staff. In total since 2013, 1,266 staff attended this type of training session.

- A summary of training delivered across the trust was requested by the ToC steering group and presented at the steering group in May 2019. A number of additional carers have expressed interest in becoming involved in planning and delivering further carer awareness training sessions and a meeting is planned for early July to take this forward.

- Although face to face training is recognised as the most valuable and effective form of training, York Carers Website continues to be promoted as an additional online training tool. 447 staff registered as completing the training up to the end of May 2019.

- Heads of Nursing continued to work with staff in their localities and the forensic service to complete community self-assessments using different approaches. This has included visits to teams and meetings to discuss progress with staff champions and managers. Overall progression with completions of the self-assessments has been monitored by the carer lead and reported to the ToC Steering group.

Staff who work in community teams recognise the benefits of involving carers during care and treatment. The ToC self-assessment tool has provided a framework for teams to assess their contact and support for carers. During training sessions discussions about consent and confidentiality have taken place and the common sense confidentiality leaflet was highlighted as a resource for staff to identify quickly what information can be shared if they were uncertain when consent is not given. Further work is planned to ensure all staff are confident with this.

Self-Assessment tools

A total of 97 completed community team ToC self-assessment tools will be included as part of the submission to the Carers Trust. The mental health services range through all ages, children's, adult and older people's and specialist services, learning disability, forensic and criminal justice are also included with the submission.

The teams included in the submission are as follows:-

1. **Durham & Darlington locality (25 teams in total)**

   Adult Mental Health Services
   Community rehabilitation & recovery team
   Darlington affective disorders
   Darlington psychosis
   Derwentside/Chester Le Street affective disorders
   Durham City affective disorders
   Easington affective
   Easington psychosis
   North Durham early intervention in psychosis (EIP)
   North Durham psychosis (including Derwentside/Chester Le Street)
   South Durham affective & access (Sedgefield)
   South Durham EIP
   South Durham Psychosis
   Wear & Dales affective

   Child & Adult Mental Health Services
   Darlington
   Easington
   North Durham
   Autistic Spectrum Diagnosis
   South Durham

Mental Health Services for Older People
Durham Liaison
South Durham community mental health team (CMHT)
North Durham CMHT

Learning Disability Services
Durham & Darlington health facilitation
Durham integrated teams (North, South & East)
Durham & Darlington specialist health team
Darlington Community team, Hundens Lane

2. **Tees locality (29 teams in total)**

Adult Mental Health Services
Adult ADHD Service
Adult autism
Hartlepool access & affective
Hartlepool psychosis including EIP
Middlesbrough access & affective
Middlesbrough psychosis including EIP
Redcar & Cleveland access & affective
Redcar & Cleveland psychosis
Redcar & Cleveland EIP
Stockton access & affective
Stockton psychosis & EIP
Tees community rehab & recovery service
Tees perinatal team
Tees Liaison Service (north & south)
Trustwide deaf service

Children's Mental Health Services
Community eating disorders service
Adolescent forensic outpatients service
Hartlepool
Middlesbrough
Redcar & Cleveland
Stockton including children's learning disability service

Mental Health Services for older People
Tees ECT
Intensive community liaison Service, Middlesbrough
South Tees (Middlesbrough & Redcar) CMHT
Stockton & Hartlepool CMHT
Adult Learning Disability Services
Kilton View, Brotton, Saltburn
South Tees Community (Middlesbrough & R&C)

North Tees Community (Stockton & Hartlepool)
The Orchard, Middlesbrough

3. North Yorkshire & York (38 teams in total)

Adult Mental Health Services
East integrated community team (ICT), Northallerton
West ICT, Colburn
Harrogate ICT
Ripon ICT
Ryedale ICT
Whitby ICT
Scarborough ICT
Scarborough street triage
Scarborough/Whitby/Ryedale EIP
Improving access to psychological therapy (IAPT) North Yorkshire
Access to mental wellbeing, York
South and west CMHT, York
North and east CMHT, York
Rehab & Recovery
York & Selby Assertive Outreach
York & Selby EIP
York IAPT

Children's Mental Health Services
Brompton House, Northallerton
Harrogate
Lake House, Scarborough
York & Selby

Mental Health Services for Older People
Hambleton & Richmondshire memory service
Hambleton & Richmondshire CMHT
Harrogate & Ripon CMHT
Harrogate memory service
Hambleton & Richmondshire acute hospital liaison
Whitby & Ryedale CMHT
Scarborough CMHT
Scarborough liaison
North & East CMHT, York
South & West CMHT, York
York liaison
York & Selby memory service
York & Selby care home & dementia team

Learning Disability Services
Hambleton & Richmondshire
Harrogate & Craven
Scarborough / Whitby / Ryedale
York

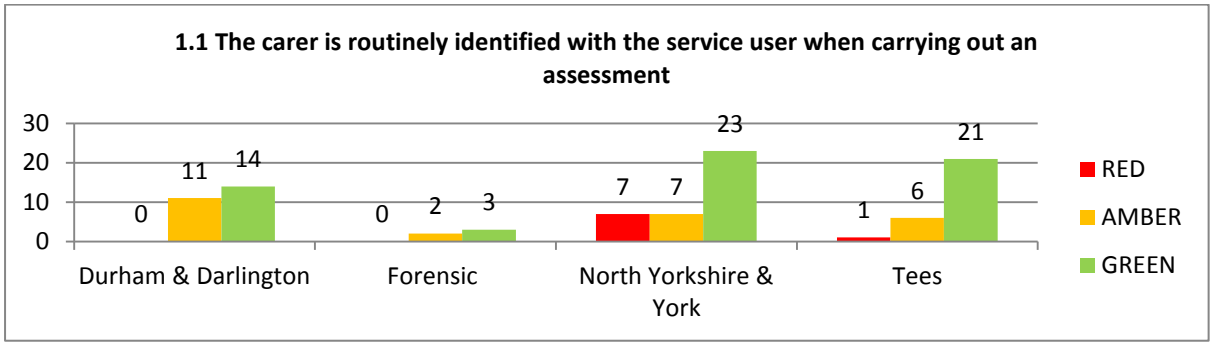
4. **Forensic Mental Health and Learning Disability Services (5 teams)**

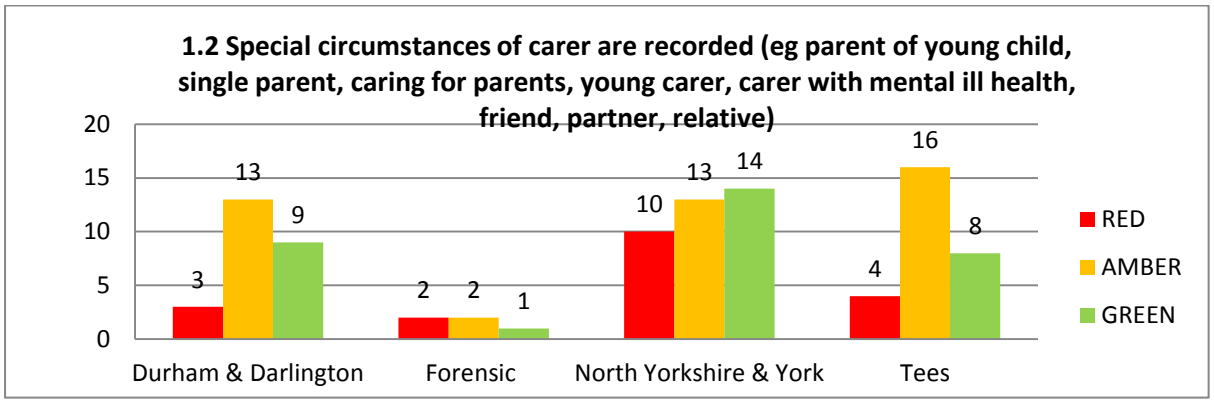
Durham & Darlington liaison & diversion
Tees liaison & diversion
Forensic outreach Service
Trustwide criminal justice liaison service
Secure outreach and transitions team

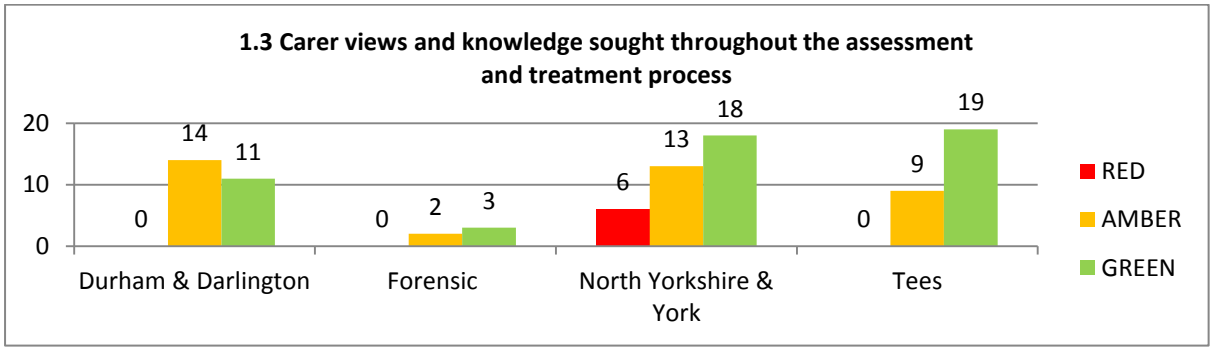
Stage 2 - Self assessments, Red Amber Green (RAG) ratings

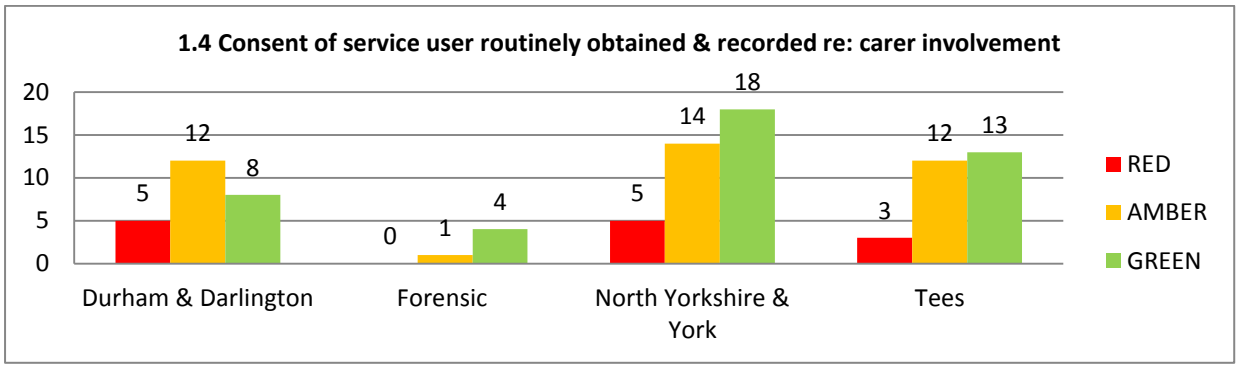
Staff were encouraged to be honest when RAG rating their service and this is reflected in the following graphs. The graphs are grouped by locality/service and relate to an analysis of 95 teams RAG ratings using the standard self-assessment tool. Two teams are not included in this analysis, Teeswide Liaison and York IAPT services as although they completed a self-assessment they did not complete all the criteria as they felt some were not appropriate for their service. The Carers Trust had previously advised that self-assessment tools could be adapted if not appropriate to the service with the priority being to carry out a review of the support offered with the self-assessment tool used as guidance for this. The two team's self-assessment documents are included in the submission.

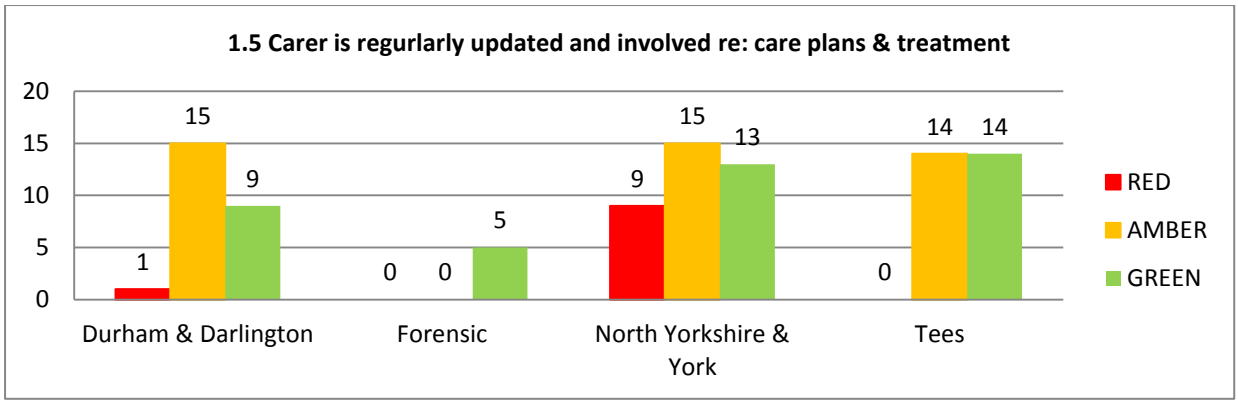
Standard 1 - Carers and their essential role are identified at first contact or as soon as possible afterwards




1.2 Special circumstances of carer are recorded (eg parent of young child, single parent, caring for parents, young carer, carer with mental ill health, friend, partner, relative)
20
15
10
5
0
3
13
9
2
2
1
10
13
14
4
16
8
Durham & Darlington
Forensic
North Yorkshire & York
Tees
RED
AMBER
GREEN


1.3 Carer views and knowledge sought throughout the assessment and treatment process
20
10
0
0
14
11
0
2
3
6
13
18
0
9
19
Durham & Darlington
Forensic
North Yorkshire & York
Tees
RED
AMBER
GREEN


1.4 Consent of service user routinely obtained & recorded re: carer involvement
20
15
10
5
0
5
12
8
0
1
4
5
14
18
3
12
13
Durham & Darlington
Forensic
North Yorkshire & York
Tees
RED
AMBER
GREEN


1.5 Carer is regurlarly updated and involved re: care plans & treatment
20
15
10
5
0
1
15
9
0
0
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13
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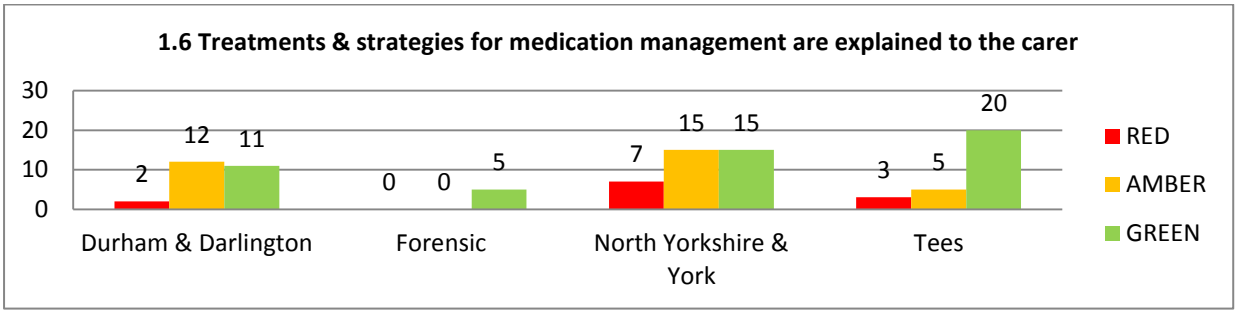
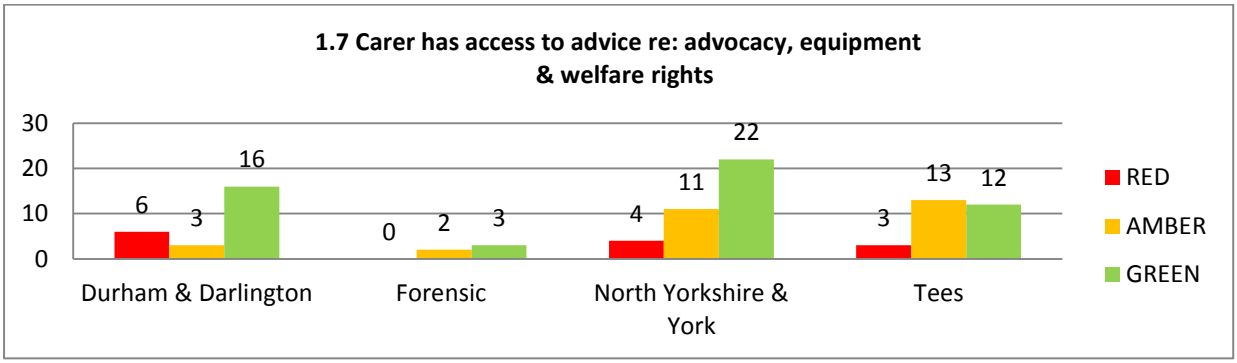
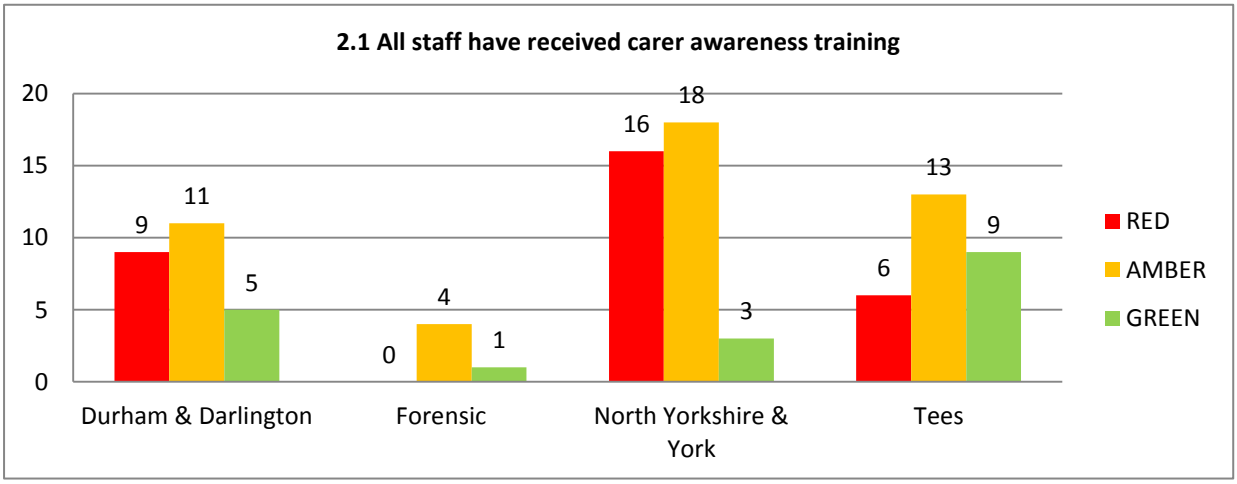
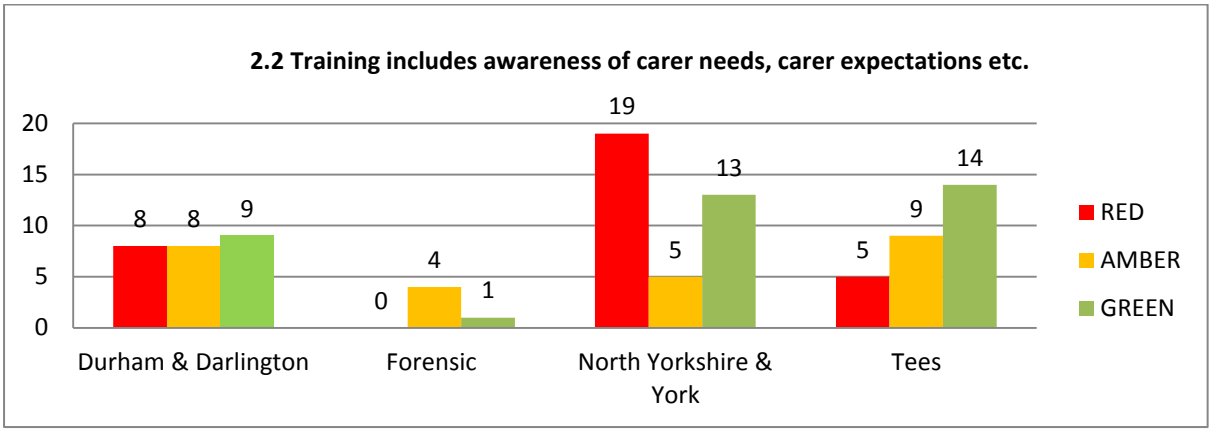
14
14
Durham & Darlington
Forensic
North Yorkshire & York
Tees
RED
AMBER
GREEN

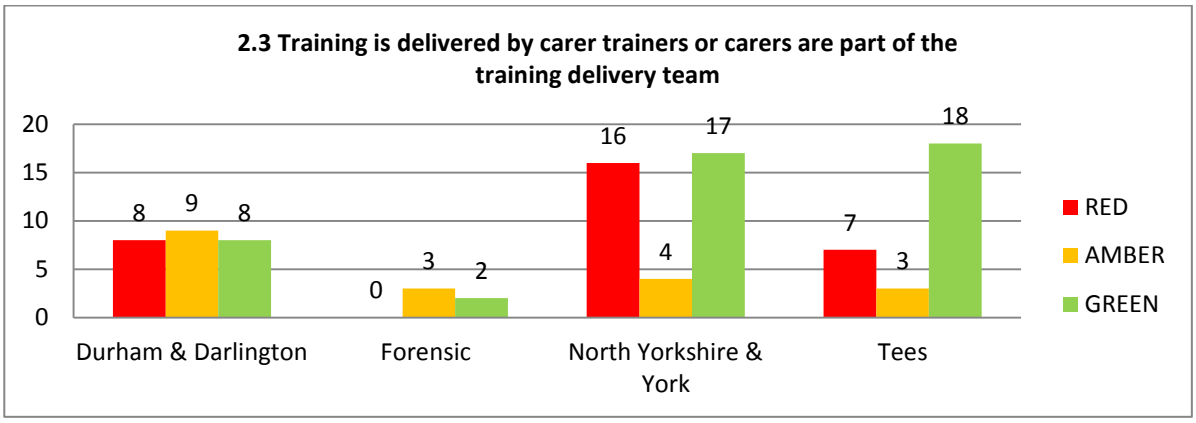




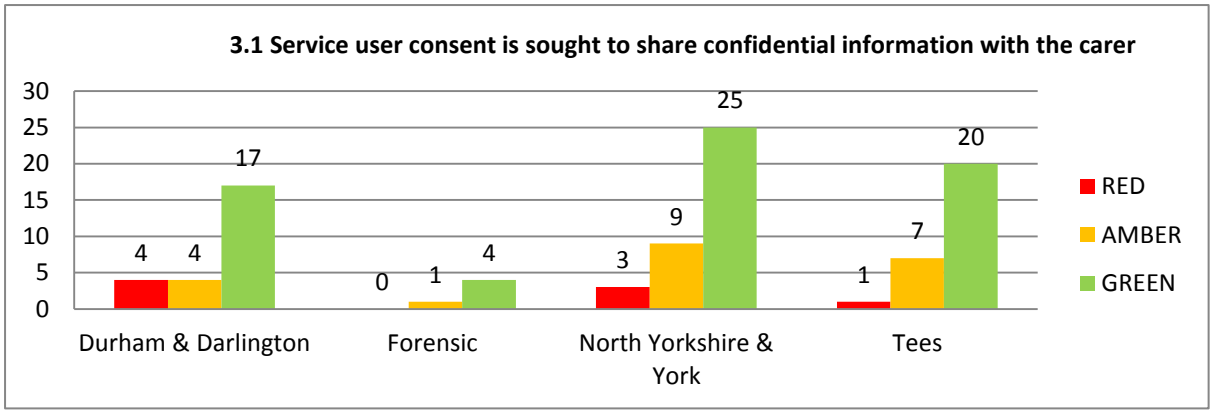
Standard 2 – Staff are carer aware and trained in carer engagement strategies

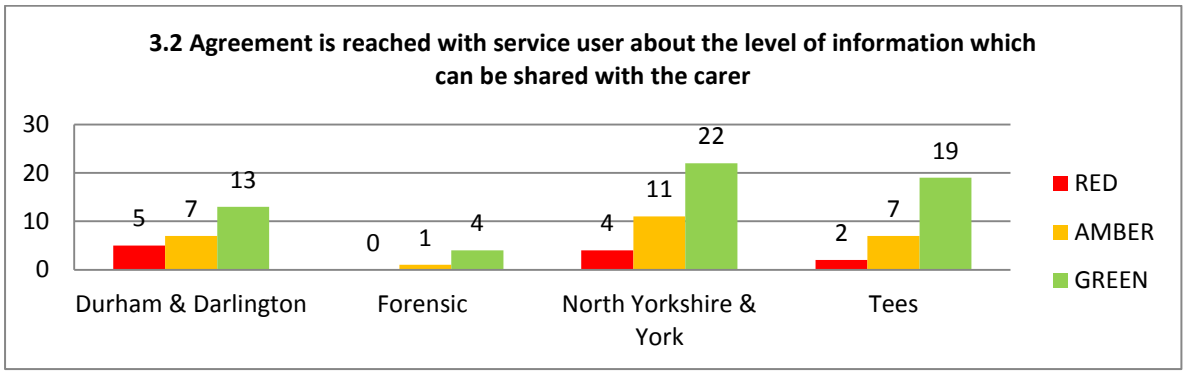


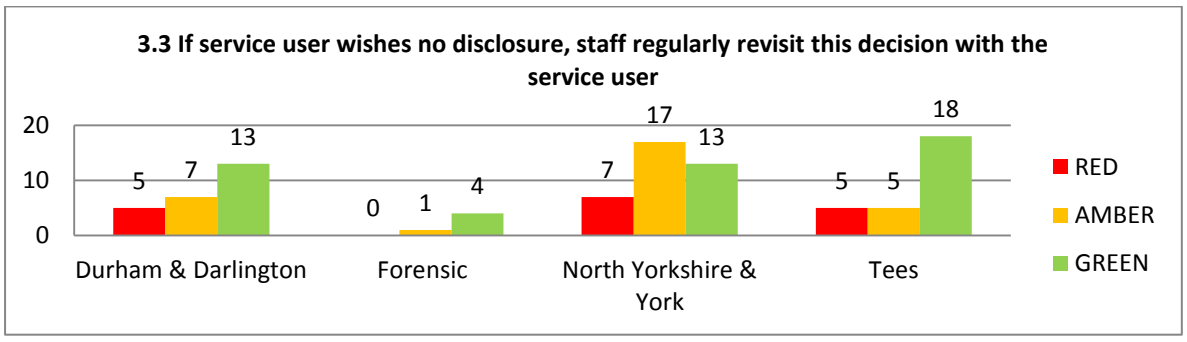


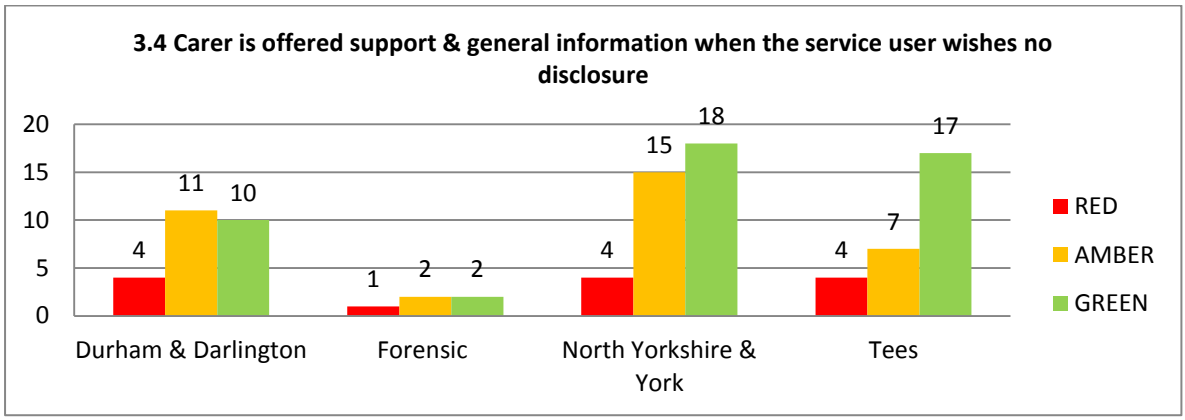


Standard 3 - Policy and practice protocols re: confidentiality and sharing information are in place








3.4 Carer is offered support & general information when the service user wishes no disclosure
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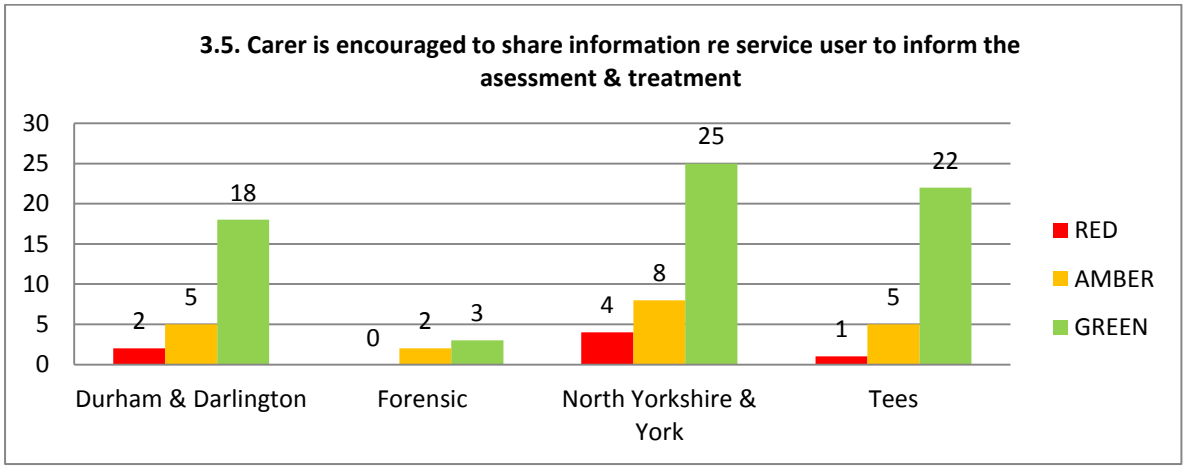
3.5. Carer is encouraged to share information re service user to inform the asessment & treatment
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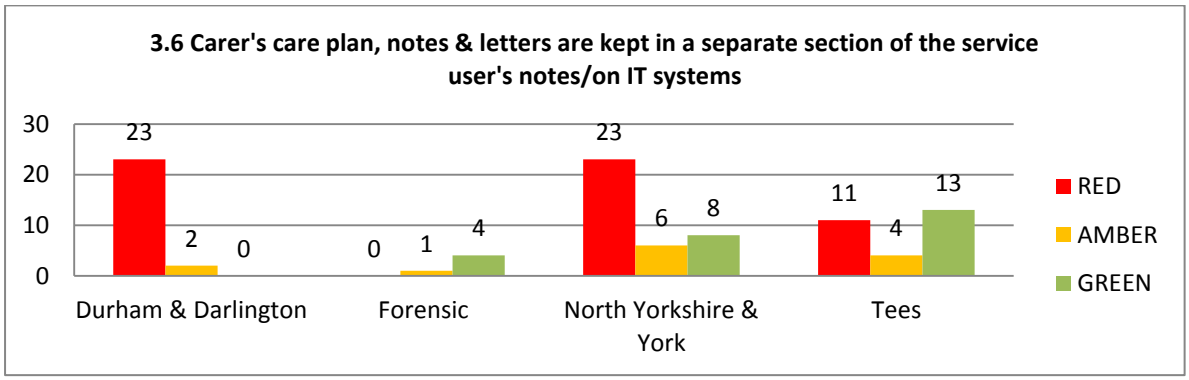
3.6 Carer's care plan, notes & letters are kept in a separate section of the service user's notes/on IT systems
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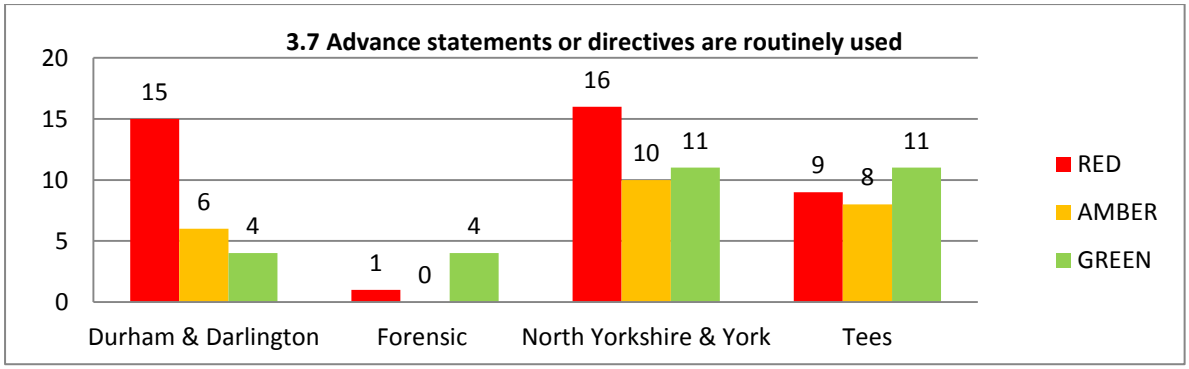
3.7 Advance statements or directives are routinely used
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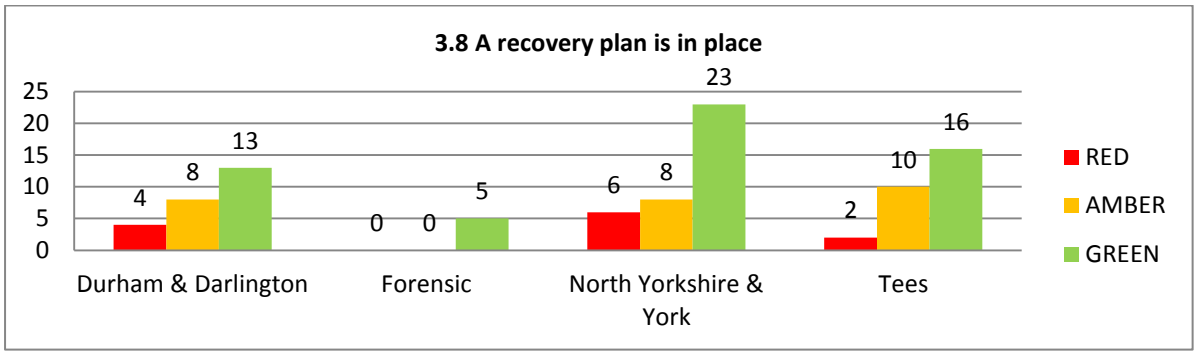
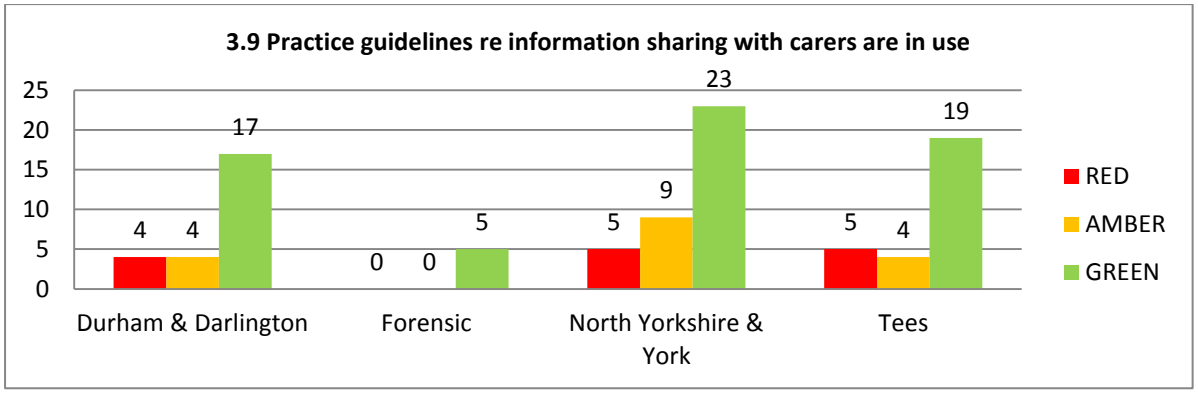
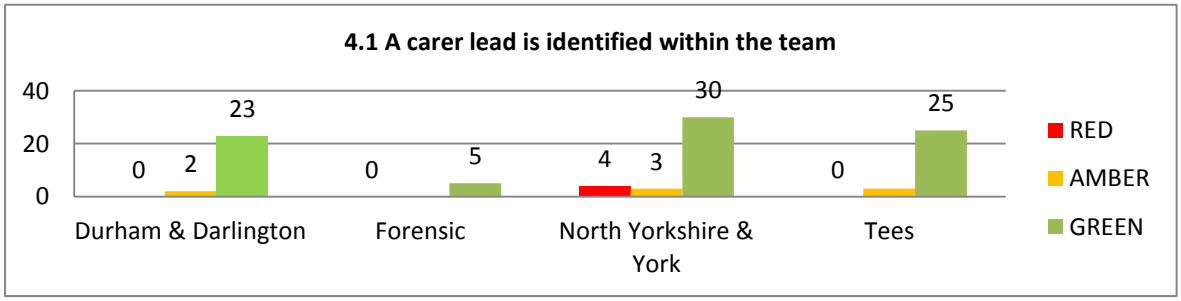
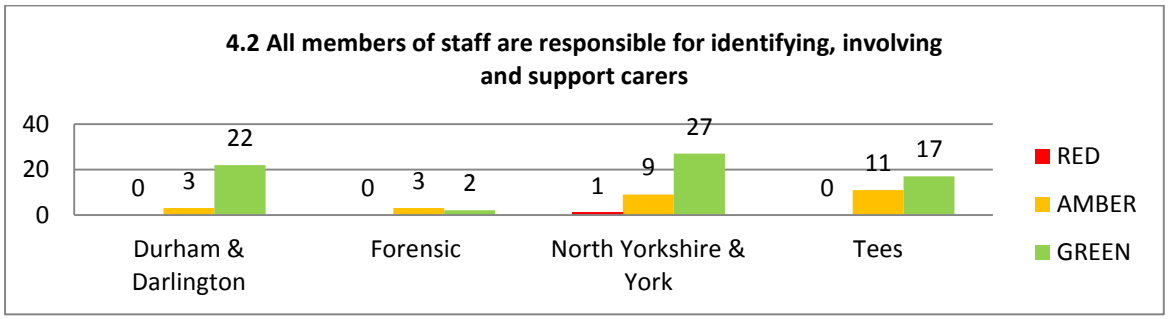
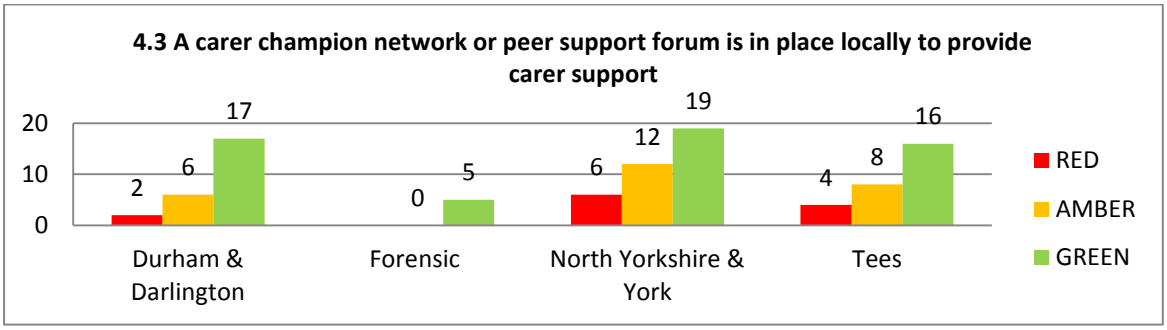




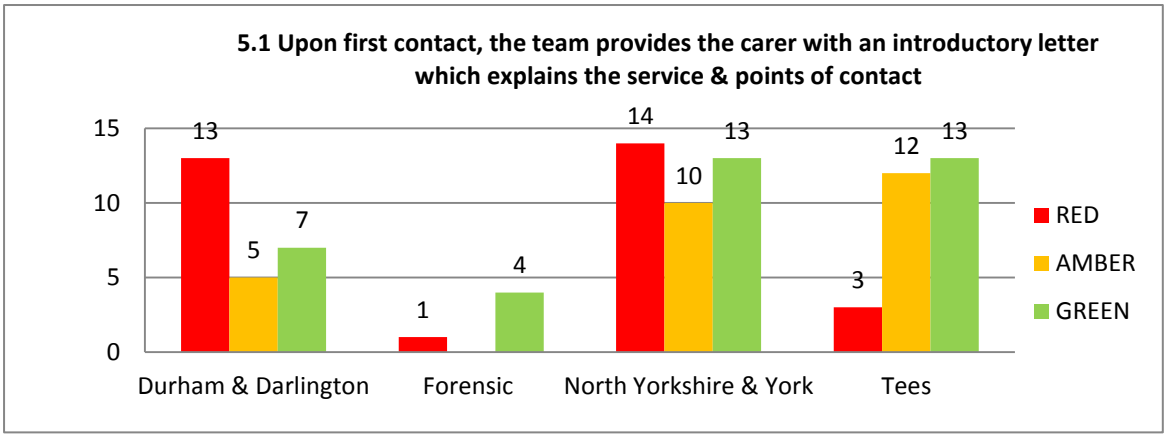
Standard 4 – Defined post(s) responsible for carers are in place

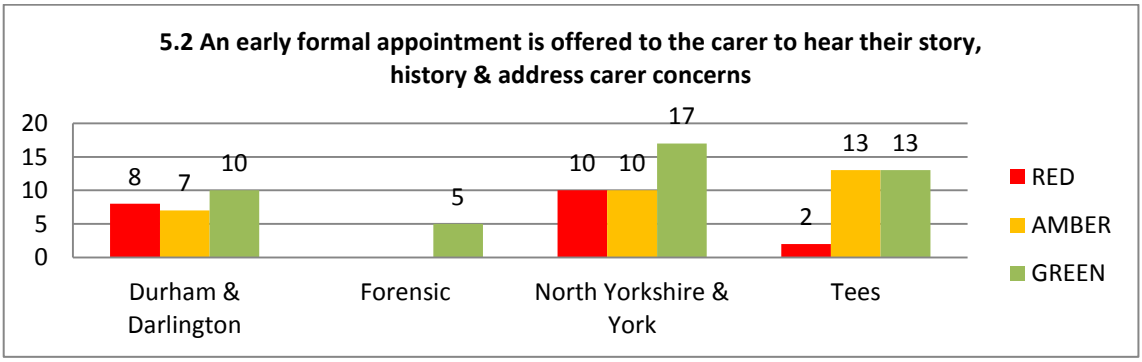


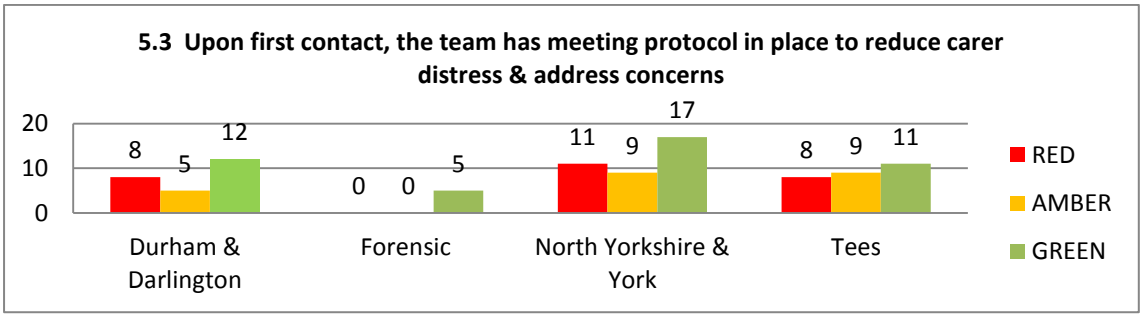


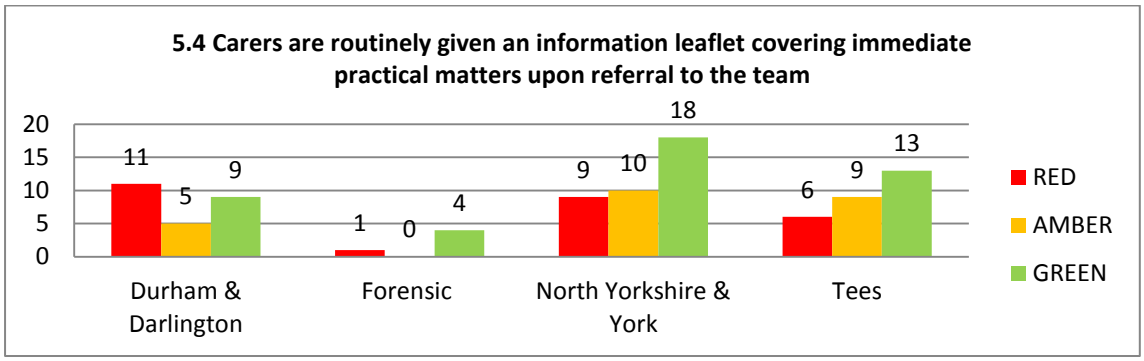


Standard 5 - A carer introduction to the service and staff is available, with a relevant range of information across the care pathway








5.4 Carers are routinely given an information leaflet covering immediate practical matters upon referral to the team
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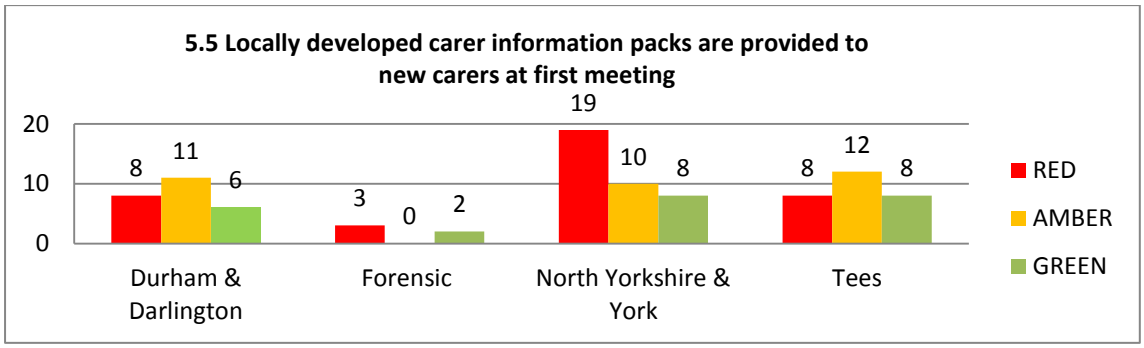
5.5 Locally developed carer information packs are provided to new carers at first meeting
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Durham & Darlington
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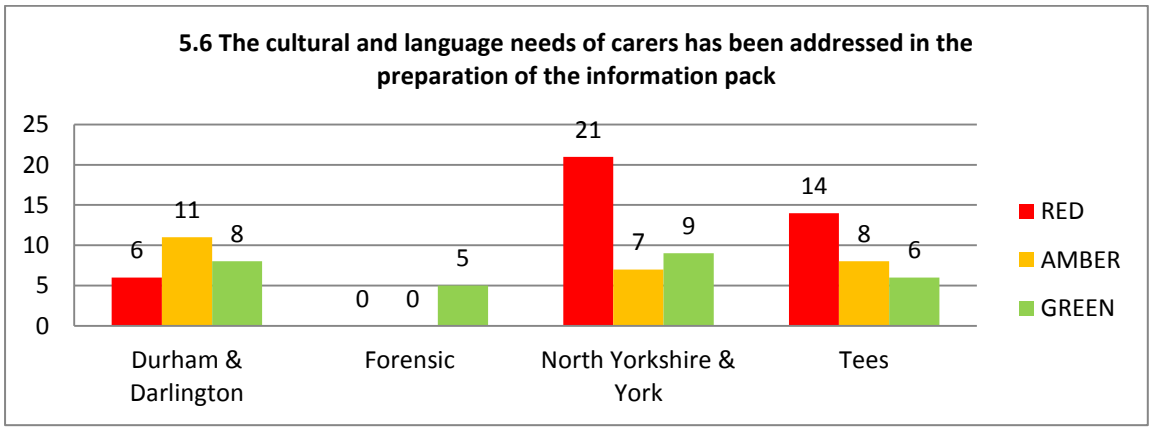
5.6 The cultural and language needs of carers has been addressed in the preparation of the information pack
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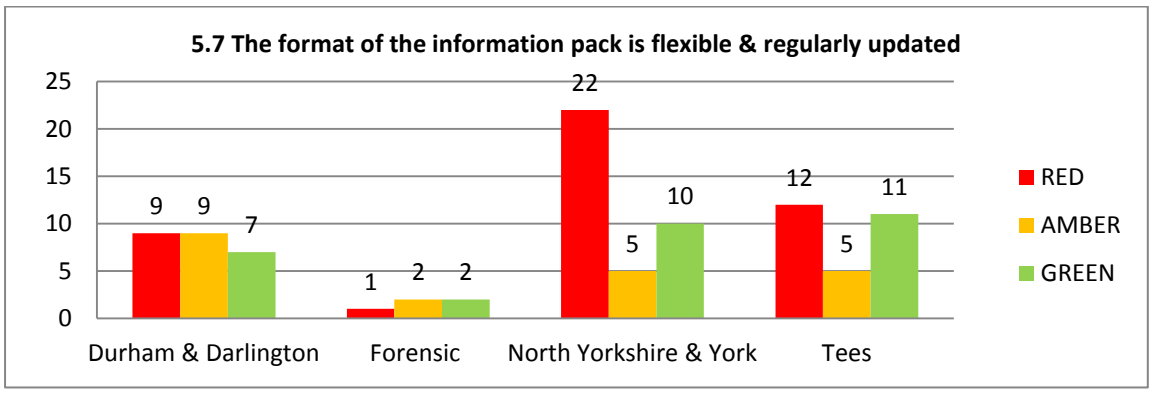
5.7 The format of the information pack is flexible & regularly updated
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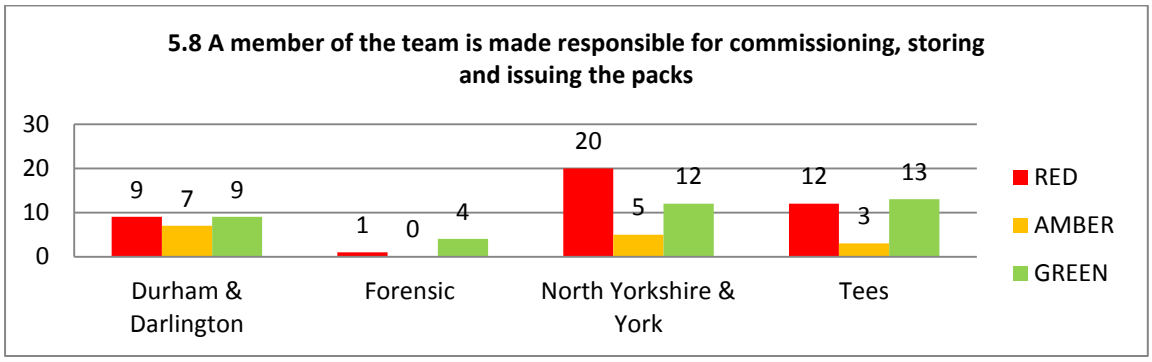
5.8 A member of the team is made responsible for commissioning, storing and issuing the packs
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Durham & Darlington
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North Yorkshire & York
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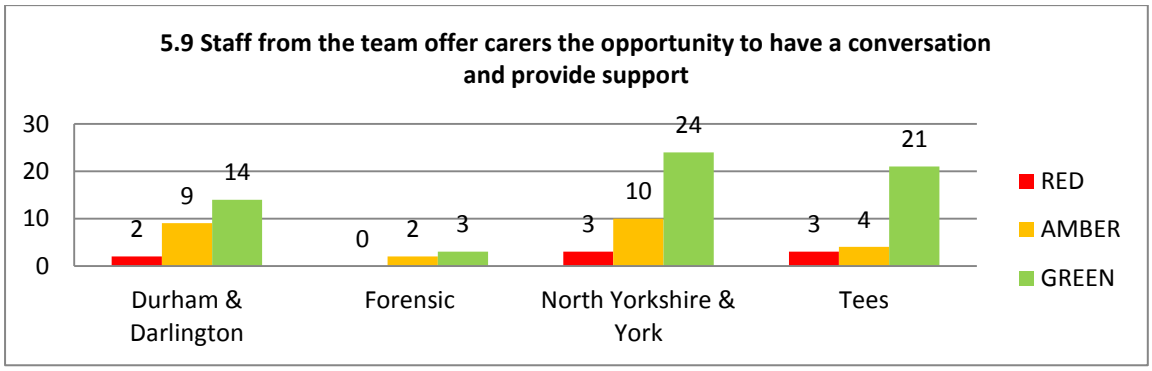
5.9 Staff from the team offer carers the opportunity to have a conversation and provide support
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Durham & Darlington
Forensic
North Yorkshire & York
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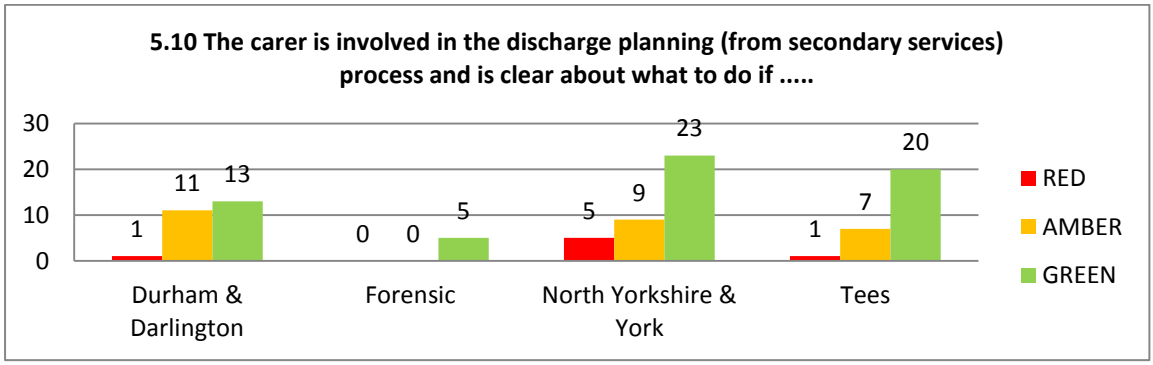
5.10 The carer is involved in the discharge planning (from secondary services) process and is clear about what to do if .....
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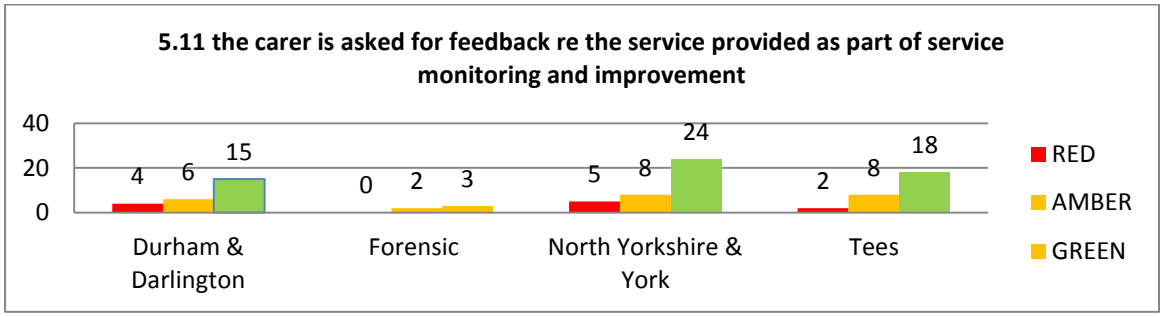
5.11 the carer is asked for feedback re the service provided as part of service monitoring and improvement
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Durham & Darlington
Forensic
North Yorkshire & York
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AMBER
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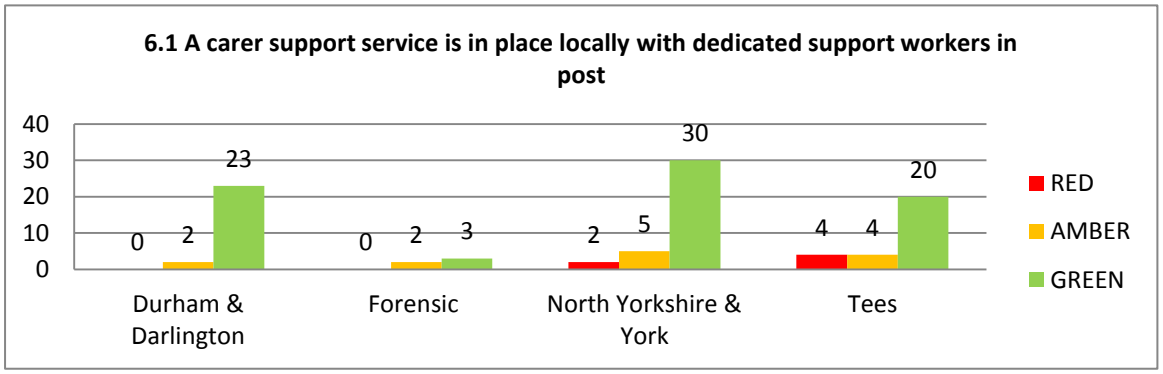
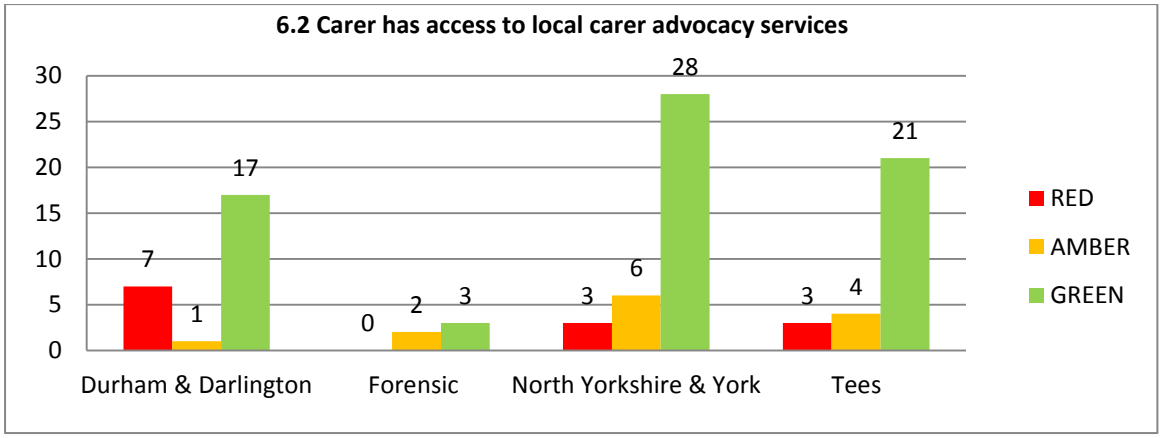
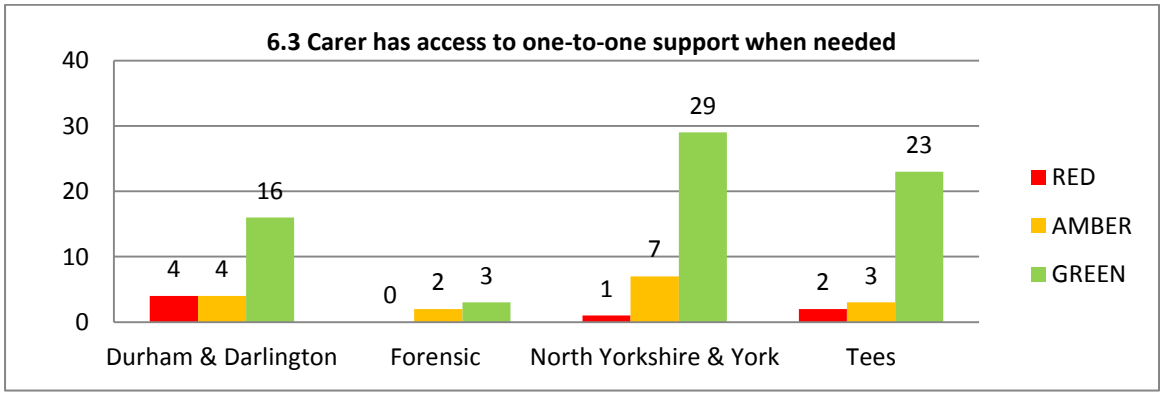
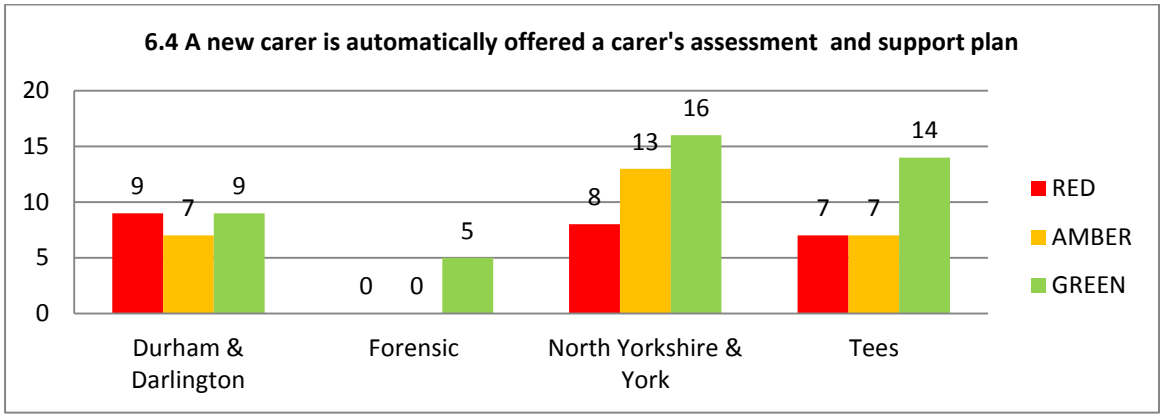
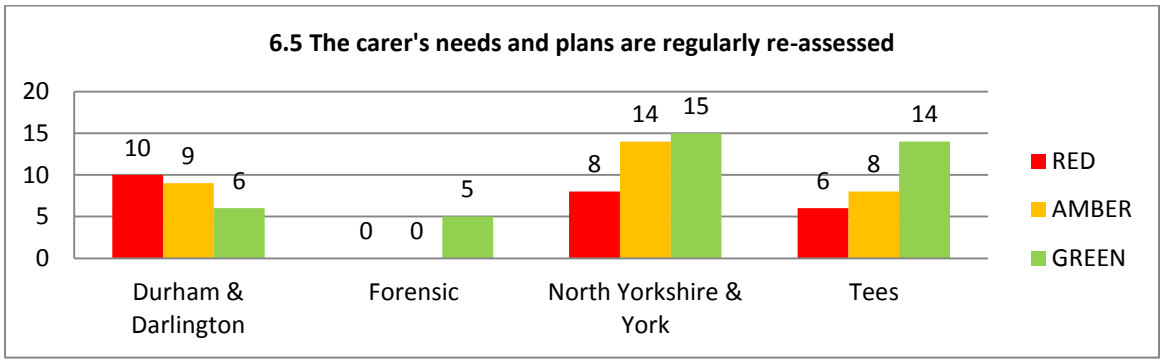
Standard 6 - A range of carer support is available

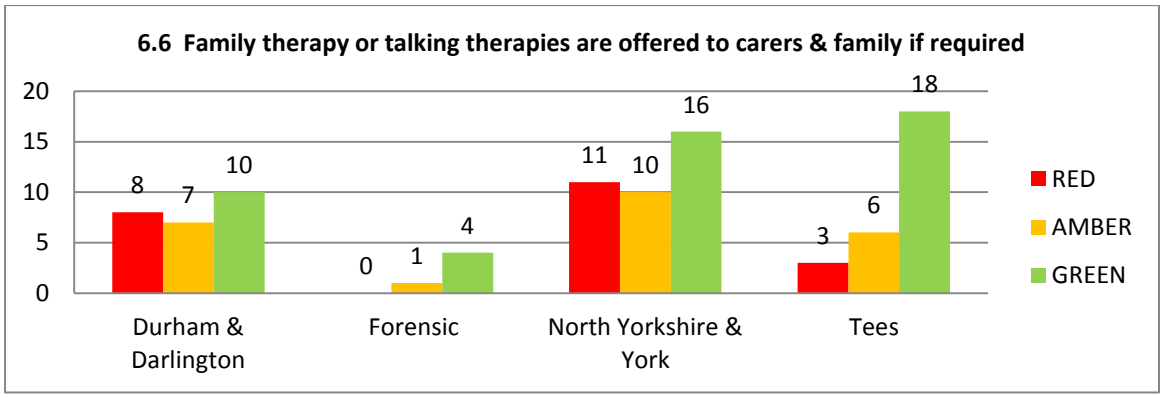












Next Steps/Action Plans –

Teams have identified their own individual actions and progress will be monitored in the localities and forensic service and by the ToC steering group. One locality with the support of the Head of Nursing has a carer who visits teams to audit progress made and this work is planned to continue. Discussions are taking place between carers to see if this can be adopted in another locality.

The trust will also continue to work with carers and carer organisations from different localities to deliver further carer awareness training.

Consideration is being given to sharing the self-assessment RAG ratings using the graphs in this report between the localities and to include examples of good practice to support learning. A suggestion has also been given to consider a half day event bringing together community team representatives from across the trust together for learning and sharing. This will be discussed at the ToC steering group.

Carer Involvement/Evidence

Carers and carer organisations from Durham, Tees, North Yorkshire, York and Tees have given support from the outset to assist the trust with the implementation of ToC through the trust steering group and involvement in carer awareness training.

Organisations who have been involved with ToC implementation are as follows:-

- Family Action Young Carers project, Durham
- Middlesbrough & Stockton Mind
- Hambleton & Richmondshire Council carer support workers
- Durham County Carers Support
- Carers Together Middlesbrough and Redcar
- Hambleton and Richmondshire Carers Centre
- Harrogate Carers Centre
- York Carers Centre

Following a request at the ToC steering group meeting in January 2019, teams submitting self-assessment tools were asked for evidence of how they were involving carers in their team's decisions around RAG rating and identifying actions.

Suggestions were given as to how carers might be involved, including using the ToC validation tool (questionnaire); through local group meetings with carers; discussions with individual carers and feedback from local carer support groups. The validation tool questionnaire was sent as a reminder together with a form to return with details of their carer involvement. In addition to the returned forms with examples from teams below, one team submitted a returned questionnaire from a carer to show how they had done this and the carer agreed this could be included in.

Following examples were given by teams as follows:-

- Carer and carer organisation representative visiting teams to discuss self-assessments
- Working with local carer organisations
- Carer survey questionnaires
- ToC validation tool used
- Carers offered a 1:1 meeting prior to engagement to introduce professionals and services available. Carers are also present in all reviews and appointments (LD Service)
- Regular contact arranged with local carers support for information sharing, good practice and regular updates
- Feedback through discussion / completion of tool with parent involved with team and will continue using this method with future carers
- Training with team included a parent to discuss what had supported them over many years involvement with service
- 1:1 discussion with carer to ascertain further information & details as to what carers actually want in regards to support / education. The carer has many years of experience in attending various support groups
- Regular contact with local carer support services, our main point of contact for carers assessment & support

- Carers' pack validated by a carer and changes made in line with carer's views
- Met two carers to check their views on our TOC self-assessment RAG ratings and collated their views on how they have found our team in relation to TOC standards
- Parent's participation groups were set up but weren't well attended and therefore have stopped
- Carers who run a carers forum were involved in assessing our carers board and new leaflets used in the clinic. They have been to talk about carers needs at a 'stop the clock' day.
- In designing new leaflets and ideas for development, the carers lead has met with individual carers who are waiting in the clinic
- Meet with carers or contact via phone, we request discharge planning meetings so carers can talk with all those involved in the hospital from the ward nurse to the physiotherapist. We work with social services and refer to carer organisations where appropriate.
- Regular attendance at family and carer's forum meeting where carer's meet with carer champions and discuss Triangle of Care and service development in terms of carer involvement
- Team has asked for informal feedback from carers

Carers feedback survey

Many teams have included the trust's carers survey as part of their evidence of asking carers about their experience when completing **Standard 5 -** ***"The carer is asked for feedback regarding the service provided as part of service monitoring and improvement"*** The data is collected from electronic devices, on paper surveys and on kiosks in team bases where there are large footfalls.

97 community teams have submitted a ToC self-assessment tool in stage 2 and between April 2018 and March 2019 these teams received a total of 5,072 completed carer surveys.

Carers are asked:-

1. Are you given the opportunity to speak about the person you care for?
2. Do you feel listened to and heard by staff?
3. Do you feel supported by staff?
4. Do you feel that staff treat you with dignity and respect?
5. Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?

Have you been given or offered information on the following?

6. Mental health conditions
7. How to raise concerns
8. How to give feedback
9. Carer support services

10. How would you rate your experience of our services?

    Excellent, Good Fair, Poor, Very poor

11. Is there anything else you would like to tell us about your experience of our services?

3,673 carers responded to question 5 above "**Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?"** From the 3,673 carers who responded, 91% (3329) responded positively with a response of either "Quite a lot" (624) or "Yes always" (2,705). Whilst this is only a sample of carers who are in contact with services, it gives some assurance that carers are being asked for feedback and majority feel they are involved in care and treatment.

Carers Conference

In May 2019, TEWV hosted a conference planned by carers, carer organisations, governors and trust staff. Carers were invited to share their journey through TEWV services and to help the trust plan the next three years of carer involvement development.

There were 25 information stands at the conference with 31 carers attending and 56 staff, including carer champions. Some carers gave presentations on their experiences and hopes for the future. All carers attending were invited to take part in any of the following sessions/workshops:-

1. **Confidentiality: Information sharing for the benefit of patients** facilitated by the Director of Nursing and Governance. An opportunity to explain practically how staff and carers can share information and work together for the benefit of the service user, discuss ideas and improvements to take forward.
2. **Carers want staff to know about caring** – **Carer Awareness Training** facilitated by a carer and Head of Nursing. A focus on what carers feel should be included in staff training.
3. **Barriers and opportunities for involvement** – facilitated by Involvement & Engagement Officers to explore different ways to get involved and to look at training opportunities that are open to carers within TEWV.

4. **Psychology Trauma** – staying open and engaged with the person cared for and the carer themselves, looking at self-care – led by a clinical nurse specialist
5. **Relaxation/Breathing** – techniques of relaxation and breathing – led by a senior wellbeing practitioner
6. **Carers rights/welfare rights** – facilitated by a welfare rights advisor
7. **Pamper session** – local college provided free hand and nail pamper sessions
8. **Chill out area** with selection of newspapers & magazines
9. **Journey wall** - available throughout the day for carers to write on what information they needed at a) point of diagnosis b) admission to hospital c) CPA d) discharge e) community services f) crisis.

The conference provided a really helpful opportunity to share ideas and focus on the priorities for TEWV moving forward as identified by the carers who attended. There was very good feedback received, carers reported they felt cared for. A further meeting is to be held in early July to discuss with carers feedback collated from conference and to discuss next steps which will include further communication on common sense confidentiality leaflet and training and an update on Trust information for carers.

Conclusion

The ToC steering group has been a very useful group for monitoring progress and with senior nursing staff leadership has ensured the targets for submission have been met.

Although the Carers Trust step by step by guide was shared with wards and teams the quality of the completed self-assessments is varied. Reassurance was given however in stage 1 by the Carers Trust that the most important thing is that in completing the self-assessments it has raised the profile of carers and teams have acknowledged where they need to make improvement through the red, amber and green marking process. Toc has given opportunity to local carer support organisations to raise their profile and explain how they can support carers, resulting in increased referrals. It is acknowledged the self-assessments are a starting point for teams and the overall continued commitment from the trust to improve carer involvement will continue.

Item no. 15

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**18 July 2019**
TITLE:	**Finance Report for Period 1 April 2019 to 30 June 2019**
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 30 June 2019 is a surplus of £1,268k, representing -0.37% of the Trust's turnover and is £67k ahead of the NHSI plan.

Performance Against Plan – year to date (3.1 / 3.2)

The Trust is currently £67k ahead of its year to date financial plan.	**Variance £000**	**Monthly Movement £000**	**Movement**
	-67	-184	↑

Cash Releasing Efficiency Savings (CRES) (3.3)

Identified CRES schemes for the financial year are forecast to be £1,666k **ahead of** financial plan.	**CRES Type**	**Annual Variance £000**	**Movement**
	Recurrent	554	↓
	Non recurrent	-2,220	↑
	Target	0	
	Variance	-1,666	↓

Identified CRES schemes for the rolling 3 year period were £9,357k **behind** the £20,565k CRES target.	**CRES Type**	**Annual Variance £000**	**Movement**
	Recurrent	9,357	↓

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.

Capital (3.4)

The Trust is £3,218k **behind of** its capital plan.	**Variance £000**	**Monthly Movement £000**	**Movement**
	-3,218	-2,285	

Expenditure against the capital programme to 30 June 2019 is £7,751k and is £3,218k behind plan due to the York and Selby inpatient facility being behind its expenditure profile, and in addition the purchase of land relating to the Worsley Court replacement has been delayed and is planned to be bought later in the financial year

Workforce (3.5)

The Trust is £574k (35%) **in excess** of its agency cap.	**Variance £000**	**Monthly Movement £000**	**Movement**
	5,274	50	

Agency expenditure continues to be high in June across all localities. Nursing (49%), Medical (31%) and Admin (14%) account for the majority of agency expenditure, which is used to support vacancies and enhanced observations with complex clients. A plan is being implemented to reduce the level of agency spend following a 10 week review based upon the NHSI diagnostic.

Use of Resources Risk Rating (UoRR) (3.7)

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

The UoRR for the Trust is assessed as 3 for the period ending 30 June 2019 and is in line with plan (Table 4). The planned rating of 3 arises due to a loan repayment of £1.5m made in April 2019 being measured against three month's income and expenditure.

However, agency expenditure continues to exceed the NHSI cap by 35% and is rated as a 3. Should this position not improve then the Trust will not achieve its planned 1 rating. 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:	**18 July 2019**
TITLE:	**Finance Report for Period 1 April 2018 to 30 June 2019**

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for 1 April 2019 to 30 June 2019.

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 ahead of plan against the control total set by NHSI.

The UoRR for the Trust is assessed as 3 for the period ending 30 June 2019 and is in line with plan. The planned rating of 3 arises due to a loan repayment of £1.5m made in April 2019 being measured against three month's income and expenditure. The Trust is ahead of its income and expenditure target by £67k however agency expenditure continues to exceed the NHSI cap by 35% and is therefore also rated as a 3.

3.2 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 30 June 2019 is a surplus of £1,268k, representing -0.37% of the Trust's turnover and is £67k ahead of the NHSI plan. This is summarised in table 1 below:

Table 1

	Annual Plan	Year to Date Plan	Year to Date Actual	YTD Variance	Prior Month Variance
	£000	**£000**	**£000**	**£000**	**£000**
Income From Activities	(346,370)	(84,212)	(84,471)	(260)	(79)
Other Operating Income	(14,746)	(3,850)	(3,710)	140	24
Total Income	**(361,116)**	**(88,062)**	**(88,181)**	**(120)**	**(55)**
Pay Expenditure	275,815	69,700	69,701	1	74
Non Pay Expenditure	70,076	14,928	15,065	137	159
Depreciation and Financing	8,920	2,232	2,147	(85)	(61)
Variance from plan	**(6,305)**	**(1,202)**	**(1,268)**	**(67)**	**117**

3.3 Cash Releasing Efficiency Savings (CRES)

The Trust's performance against the 2019/20 CRES target is shown in Table 2 below. The Trust is anticipating being ahead of plan (£1,666k) at the financial year end and continues to identify schemes for future years.

Table 2 Identified CRES schemes for the financial year are forecast to be £1,666k ahead of financial plan.	**CRES Type**	**Annual Variance £000**	**Movement**
	Recurrent	554	↓
	Non recurrent	-2,220	↑
	Target	0	
	Variance	-1,666	↓

3.4 Capital

Expenditure against the capital programme to 30 June 2019 is £7,751k and is £3,218k behind plan due to the York and Selby inpatient facility being behind its expenditure profile, and in addition the purchase of land relating to the Worsley Court replacement has been delayed and is planned to be bought later in the financial year.

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 June-19	Jan	Feb	Mar	April	May	June
Establishment (a) (90%-95%)	91.59%	93.03%	92.24%	92.38%	90.66%	90.89%	91.59%
Agency (b)	1.00%	3.44%	3.52%	3.51%	4.07%	3.50%	3.20%
Overtime (c)	1.00%	1.02%	1.03%	1.02%	1.20%	0.94%	0.90%
Bank & ASH (flexed against establishment) (100%-a-b-c)	6.41%	3.13%	3.09%	2.99%	3.10%	3.20%	3.50%
Total	**100.00%**	**100.62%**	**99.88%**	**99.98%**	**99.03%**	**98.51%**	**99.11%**

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 June 2019 the tolerance for Bank and ASH is 6.41% of pay budgets.

NHS Improvement monitors agency expenditure against a capped target. Agency expenditure at 30 June 2019 is £2,229k which is £574k (35%) in excess of the agreed year to date capped target of £1,103k. Nursing and Medical agency expenditure accounts for 80% of total agency expenditure, 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 30 June 2019 is £ 62,880k which is £10,147k ahead of plan due to higher than anticipated creditor accruals where invoices have not been received by the Trust, and underspends on the capital programme.

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 30 June 2019 and is in line with plan (Table 4). The planned rating of 3 arises due to a loan repayment of £1.5m made in April 2019 being measured against three month's income and expenditure. The UoRR is planned to improve throughout the financial year to a 2 rating.

However, in addition the Trust is ahead of its income and expenditure target (£67k) although agency expenditure continues to exceed the NHSI cap by 35% and is rated as a 3. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

Should this position not improve then the Trust will not achieve its planned 1 rating and may also not receive its Provider Sustainability Funding allocation

Table 4: Use of Resource Rating at 30 June 2019

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		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	0.81x	4	1.15x	4	
Liquidity	70.6 days	1	71 days	1	
I&E margin	1.4%	1	1.4%	1	
I&E margin distance from plan	0.0%	1	0.0%	1	
Agency expenditure	£2,229k	3	£1,654k	1	
Overall Use of Resource Rating		**3**		**3**	

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 0.81x (can cover debt payments due 0.81 times), which is in line with plan.

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 70.6 days; this is slightly behind of plan, but still 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 1.4%, which is on plan and is 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 0.04% which is on plan and rated as a 1.

The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is 35% higher than the capped target and is rated as a 3.

The margins on UoRR are as follows:

- Capital service cover - to improve to a 3 a surplus increase of £1,272k is required.
- Liquidity - to reduce to a 2 a working capital decrease of £66,074k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £345k is required.
- I&E margin distance from plan – to reduce to a 2 an operating deficit increase of £67k is required.
- Agency Cap rating – to improve to a 2 a reduction in agency expenditure of £161k 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 For the period ending 30 June 2019 the Trust is £67k ahead of its planned control total surplus (£1,201k) submitted to NHSI.

6.2 The amount of CRES identified for the financial year is ahead of plan and the Trust continues to identify schemes to ensure full delivery of recurrent CRES requirements for the 3 year rolling programme.

6.3 The UoRR for the Trust is assessed as 3 for the period ending 30 June 2019 and is in line with plan (Table 4). The planned rating of 3 arises due to a loan repayment of £1.5m made in April 2019 being measured against three month's income and expenditure. The UoRR is planned to improve throughout the financial year to a 2 rating.

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 NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**18th July 2019**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

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

Executive Summary:

This report provides information on the use of the Trust Seal as required under Standing Order 15.6.

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**18th July 2019**
TITLE:	**Report on the Register of Sealing**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board of Directors of the use of the Trust's Seal in accordance with Standing Orders.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 An entry of every sealing is made and numbered consecutively in a Register specifically provided for the purpose. It is signed by the persons who have approved and authorised the document and those who attested the seal.

3. KEY ISSUES:

3.1 The Trust Seal has been used as follows:

Number	Date	Document	Sealing Officers
348	20/06/2019	Construction Framework Agreement with Esh Construction Ltd	Colin Martin, Chief Executive Phil Bellas, Trust Secretary
349	20/06/2019	Construction Framework Agreement with Kier Construction Ltd	Colin Martin, Chief Executive Phil Bellas, Trust Secretary
350	20/06/2019	Construction Framework Agreement with Interserve Construction Ltd	Colin Martin, Chief Executive Phil Bellas, Trust Secretary
351	20/06/2019	Construction Framework Agreement Deed of Guarantee with Kier Ltd	Colin Martin, Chief Executive Phil Bellas, Trust Secretary
352	20/06/2019	Construction Framework Agreement Deed of Guarantee with Esk Holdings Ltd	Colin Martin, Chief Executive Phil Bellas, Trust Secretary

4. IMPLICATIONS:

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

4.2 **Financial/Value for Money:** None identified.

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

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

7.1 The Board is asked to receive and note this report.

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution
Seals Register