# AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS THURSDAY 23RD JULY 2015
# VENUE: THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

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| **Item 1** | To approve the public minutes of the meeting of the Board of Directors held on **23rd June 2015**. | | **Attached** |
| **Item 2** | Public Board Action Log. | | **Attached** |
| **Item 3** | Declarations of Interest. | | |
| **Item 4** | Chairman's Report. | **Chairman** | **Verbal** |
| **Item 5** | To consider any issues raised by Governors. | **Board** | **Verbal** |

Quality Items (9.45 am)

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| **Item 6** | To receive a briefing on key issues in the Teesside Locality. | **David Brown to attend** | **Presentation** |
| **Item 7** | To consider the report of the Quality Assurance Committee. | **JR/CS** | **Attached** |
| **Item 8** | To consider the annual Nurse Staffing Report. | **CS** | **Attached** |
| **Item 9** | To receive and note a progress report on the Francis 2 Action Plans. | **MB** | **Attached for information** |
| **Item 10** | To receive and note a progress report on the 5th Malcolm Rae Action Plan. | **CS** | **Attached for information** |
| **Item 11** | To receive and note the business case for the Smoking Cessation and Nicotine Management Project. | **NL** | **Attached** |

Strategic Items (10.45 am)

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| **Item 12** | To approve amendments to the "this means that" statements supporting the Strategic Goals. | **SP** | **Attached** |

*Refreshment break*

Performance (11.00 am)

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| **Item 13** | To consider the summary Finance Report as at 30th June 2015. | **DK** | **Attached** |
| **Item 14** | To consider the Trust Performance Dashboard as at 30th June 2015. | **SP** | **Attached** |
| **Item 15** | To consider the Trust Workforce Report as at 30th June 2015. | **DL** | **Attached** |

Governance (11.35 am)

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| **Item 16** | To approve the Quarter 1, 2015/16 Risk Assessment Framework submission to Monitor. | **PB** | **Attached** |
| **Item 17** | To consider a progress report on the Governance Action Plans. | **MB** | **Attached** |

Items for Information (11.45 am)

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| **Item 18** | Policies and Procedures ratified by the Executive Management Team. | **MB** | **Attached** |

**Item 19** To note that the next meeting of the Board of Directors will be held in conjunction with a seminar on **Tuesday 18th August 2015** in the Board Room, West Park Hospital, Darlington at 9.30 am.

Confidential Motion (11.50 am)

**Item 20** **The Chairman to move:**

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

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

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

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

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

**Mrs. Lesley Bessant**
**Chairman**
**17th July 2015**

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

# MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 23RD JUNE 2015 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 AM.

**Present:**
Mrs. L. Bessant, Chairman
Mr. M. Barkley, Chief Executive
Mr. J. Tucker, Deputy Chairman
Dr. H. Griffiths, Non-Executive Director
Mr. M. Hawthorn, Non-Executive Director
Mr. D. Jennings, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Mr. B. Kilmurray, Chief Operating Officer
Dr. N. Land, Medical Director
Mr. C. Martin, Director of Finance and Deputy Chief Executive
Mrs. C. Stanbury, Director of Nursing and Governance
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

**In Attendance:**
Mrs. M. Booth, Public Governor for Middlesbrough
Miss. V. Wildon, Public Governor for Redcar and Cleveland
Mr. G. Davidson, BT Health Team
Mr. N. Ayre, York Mind
Mr. P. Bellas, Trust Secretary
Ms. C. McCann, Associate Director of Nursing
Mrs. J. Illingworth, Director of Quality Governance
Mrs. J. Jones, Head of Communications
Mrs. K. Ord, Deputy Trust Secretary
Ms. J. Rogerson, Modern Matron

Ms. L. Brack, Ms. C. Brogden, Ms. L. Campbell and Ms. C. Carcea, student nurses

## 15/160 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. J. Robinson, Senior Independent Director and Mrs. B. Matthews, Non-Executive Director.

Mr. Hawthorn apologised for having to be absent from part of the meeting (minutes 15/172 to 15/177 refer) in order to attend another engagement.

## 15/161 MINUTES

***Agreed*** *– that the public minutes of the special meeting held on 12th May 2015 and the last ordinary meeting held on 26th May 2015 be approved as correct records and signed by the Chairman.*

## 15/162 PUBLIC BOARD ACTION LOG

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

Arising from the report:

(1) In response to a question, and further to minute 15/131 (26/5/15), it was noted that the use of bank staff on Westerdale South Ward had reduced from over 1200 hours in January 2015 to approximately 400 hours in June 2015 following an increase in permanent staffing on the unit.

(2) It was noted that, following discussions with Mr. Kilmurray, Mrs. Pickering would be providing Board Members with the data on waiting times requested under minute 15/132 (26/5/15).

(3) Mrs. Pickering confirmed that the Quality Account/Report 2014/15 had been posted on the NHS Choices website and, therefore, the relevant action under minute 15/136 (26/5/15) had been completed.

(4) The Chairman reported that she had sent a letter of condolence to the widow of the late Cllr Robin Todd (minute 15/144 – 26/5/15 refers).

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

**Action: Mr. Bellas**

## 15/163 DECLARATIONS OF INTEREST

There were no declarations of interest.

## 15/164 CHAIRMAN'S REPORT

Mrs. Bessant reported on her activities since the last meeting as follows:

(1) Opened the Staff Health and Wellbeing Conference on 22nd June 2015.

The Chairman highlighted:

(a) The enthusiasm of staff who had attended the Conference.

(b) The performance by the Trust Choir at the event which had been very impressive.

Board Members supported the Chairman's suggestion that the Trust's Choir should be invited to perform at the forthcoming Annual General/Annual Members' Meeting.

**Action: Mr. Bellas**

(2) Presented a "living the values" award to Ms. Ellie Sweeney, a healthcare assistant on Maple Ward, West Park Hospital, who had been nominated by a service user for the significant positive impact she had made to their wellbeing.

(3) Attended the NHS Providers Chairs' and Chief Executives' meeting in London on 16th June 2015.

The Chairman reported that discussions on the financial position of the NHS had dominated the event. These had focussed on:

(a) The likelihood of the additional funding for the NHS not being made available until towards the end of the current Parliament.
(b) The requirement for the financial deficit during the present financial year to be no greater than that planned for 2014/15.
(c) The "Five Year Forward View" being viewed as the key means of addressing the deficit; however, actions to be taken in the short term remained unclear.
(d) The risks of greater central control, and a weakening of Foundation Trust autonomy, under the influence of HM Treasury.
(e) The position of the Secretary of State for Health on these matters.

In addition Mrs Bessant advised that at the meeting:

(a) Clarity had been sought on the Government's future approach to mental health and it had been noted that a "five year game plan" for the sector was being developed. NHS England had established a Mental Health Taskforce which was due to report in the summer.
(b) Integration had been discussed with the key message being that providers should take whatever action they considered necessary to make services more effective and efficient.

**15/165 GOVERNOR ISSUES**

No issues were raised.

**15/166 QUALITY ASSURANCE COMMITTEE**

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

(1) The confirmed minutes of its meeting held on 7th May 2015 (Appendix 1 to the report).
(2) The key issues discussed by the Committee at its meeting held on 4th June 2015.
(3) The Patient Safety and Patient Experience Data Report for April 2015 (Appendix 2 to the report).

Mrs. Stanbury:

(1) Drew attention to the note in the report (further to minute 15/39 - 24/2/15) on the outcome of the review, undertaken by the Patient Safety Group, into the apparent excess of unexpected deaths in the County Durham and Darlington Locality.

The Board noted that whilst the number of unexpected deaths in the Locality was comparatively high, based on the rate of population, if the figures were standardised on the number of service users on the open caseload, there was no significant variance against other Localities.

Dr. Land advised that the issue would continue to be monitored and a rolling programme of reviews of unexpected deaths by service had been instituted by the Group.

Mrs. Stanbury considered that future reporting on unexpected deaths should include actual total numbers, numbers per head of population, and the rate per service user on the open caseload.

(2) At its meeting held on 10th June 2015 the Executive Management Team had agreed a new model for clinical supervision which included a mandate for nurses in line with other clinical staff groups.

It was noted that a pragmatic approach was being taken to the implementation of the new model.

The focus of the Board's discussions was on compliance with NICE guidelines in view of the annual audited outturn position being 9.09% against a target of 85%.

Dr. Land explained that the position arose from the construction of the indicator which was based on the percentage of audits where full compliance could be evidenced with all elements of a guideline in each service. He considered that this approach should be changed with the indicator measuring the number of guidelines where compliance achieved was, say, at or above 90%.

The Board also noted that the Trust had been commended by NICE for its significant efforts to comply with its guidelines.

In response to a question, Dr. Land advised that variance from the guidelines was permitted if compliance was impracticable and the reasons for this were evidenced. This would be reflected in the audits.

In addition, with regard to the minutes of the meeting of the Committee held on 7th May 2015, it was noted that:

(1) Notwithstanding her name being included in the attendance list, Mrs. Pickering had not been present at the meeting.

(2) The action under minute 15/73, on the deferral of the next six monthly nurse staffing report, from June to July 2015, to enable all CRES data to be included, was due to be actioned by Mrs. Stanbury and not, as stated, by Mr. Levy.

(3) Mr Levy would be reviewing performance on the indicator "percentage of new employees receiving equality and diversity training within 8 weeks" as it was considered that the figure of 51% (committee minute 15/75 refers) was understated.

Mr Levy advised that the outcome of his review would be included in the next quarterly Workforce Report.

**Action: Mr. Levy**

**15/167 NURSE STAFFING REPORT**

The Board received and noted the report on nurse staffing for May 2015 as required to meet the commitments of "Hard Truths", the Government's response to the Public Inquiry into Mid Staffordshire NHS Foundation Trust (the "Francis Review").

Mrs. Stanbury advised that:

(1) Further to minute 15/162 above, although usage of bank staff on Westerdale South Ward had reduced it still remained comparatively high.

(2) The triangulation of data on nurse staffing with that for other quality indicators e.g. complaints, SUIs, etc. was continuing. No issues had been identified to date.

It was also noted that the fill rate for Springwood, despite month on month improvement, remained low. This was attributed to its isolated location and related recruitment problems with limited local population.

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

(1) The decrease in the fill rate for registered nurses on Thistle Ward to 66.4% which had been attributed to the ward regularly supporting other areas.

Mrs. Stanbury explained that the ward establishment included two registered nurses. If the ward was quiet one registered nurse could be moved across to another ward, if required, to provide additional capacity. This would be recorded as a shortfall on Thistle Ward's fill rate.

In addition, it was noted that the increase in the fill rate for healthcare assistants on the ward suggested that these staff were being used to cover the shortfall on registered nurses at those times.

(2) The position on the national development of guidance on safe staffing levels in mental health services following the announcement by NICE that its work on this matter had been suspended.

Mrs. Stanbury reported that:

(a) The work of NICE on safe staffing guidelines had been focussed, to date, on acute services.

(b) The Chief Nursing Officer, in a letter dated 11th June 2015, had recognised that good quality care was influenced by a range of factors and advised that, in developing its approach to safe staffing in mental health and community services, NHS England would be taking a broader perspective focussing on multi-disciplinary teams and different models of care. Its findings, which would have the same status as NICE guidelines, were due to be published by the end of the year.

(c) NHS England had also acknowledged that the tools developed for acute settings were inappropriate for mental health services.

(3) The staffing position on Maple Ward which showed a high rate of bank staff but also staffing fill rates in excess of 100%.

Mrs. Stanbury advised that prior booked bank staff would be included in the fill rate. A fill rate of over 100% could occur when a booking had been made to cover known sickness absence but the member of staff returned to work earlier than expected, or where additional staff were required to deliver higher levels of engagement and observation.

In response to a question it was noted that the staffing establishment on the ward was planned on the basis that all beds would be filled.

In addition:

(1) Mrs. Stanbury undertook to address the transposition of the column headings in Appendix 1 to the report.

**Action: Mrs. Stanbury**

(2) Board Members highlighted the improvements to reporting on nurse staffing over the past 12 months and commended Ms. Emma Haimes for her work on this matter.

(3) It was noted that the first annual report on nurse staffing would be presented to the next Board meeting to be held on 23rd July 2015.

**15/168 OUT OF LOCALITY ADMISSIONS ACTION PLAN**

Further to minute 14/198 (24/6/15) consideration was given to a progress report on the Out of Locality Admissions Action Plan.

Copies of the data tables, which had been embedded in the report, were tabled at the meeting.

The Executive Directors were asked to be mindful of the difficulties experienced by the Non-Executive Directors in accessing embedded documents when preparing their reports.

**Action: All Executive Directors**

Mr. Kilmurray reported that:

(1) As previously discussed, the issues relating to out of locality admissions were very complex.

(2) The Trustwide action plan had been developed to supplement Locality action plans.

(3) Performance on out of locality admissions had improved; however, the extent this could be attributed to the implementation of the action plan was unclear.

(4) Difficulties had been experienced in recruiting to the Expert Practitioner post. An interim appointment had been made and the post holder was making a significant impact.

(5) As shown in Appendix 1 to the report, the majority of the actions had been completed. However, the Board was being asked to approve an extension to the timescale for the development of training materials and the rolling out of training to all CRT staff (action ref. no. 1) from March to September 2015 as a consequence of the delays in appointing to the Expert Practitioner role.

(6) Issues in certain Localities (e.g. Sedgefield, The Dales, and Harrogate) remained and these would be discussed at the next round of Performance Improvement Group meetings.

The Non-Executive Directors sought clarity on:

(1) The learning taken from the review of out of locality admissions in Richmondshire and its application to other Localities.

Mr. Kilmurray advised that:

(a) The findings of the review were summarised in the report.
(b) As expected, the review had found that the reasons for out of locality admissions in Richmondshire were complex and multi-faceted.
(c) The key issues were the patterns of referrals from certain GPs and a significant number of out of hours admissions of people not on the caseload.
(d) In response the service was developing a programme of work which included increased GP liaison and building stronger relationships between the CMHT and the Crisis Team.
(e) In-depth audits of out of locality admissions had not been undertaken in other Localities. Whilst each area would be expected to have different issues, the need to improve the skill base in CRHTs and manage capacity and demand were probably common to all areas.

(2) Whether there was a correlation between SUIs and reductions in bed occupancy.

In response it was noted that, whilst this matter had not been reviewed and would require a bespoke piece of work, it appeared that where bed numbers had been reduced (e.g. on Teesside) there had also been a decrease in the number of SUIs.

***Agreed*** *– that the proposal to extend the timescale for the development of training materials and the rolling out of training to all CRT staff (action ref. no. 1) from March to September 2015 be approved.*

**Action: Mr. Kilmurray**

## 15/169 MENTAL HEALTH LEGISLATION COMMITTEE

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

(1) The confirmed minutes of the meeting held on 19th February 2015 (Appendix 2 to the report).
(2) The key issues considered by the Committee at its meeting held on 27th April 2015.

Mr. Simpson highlighted the following matters:

(1) The significant impact of the revised Code of Practice.
(2) The increase in activity over the last quarter which was being monitored.

Mr. Simpson advised that previously, as reported under minute 15/67 (24/3/15), activity had plateaued following a “spike” related to the Cheshire West judgment.

(3) The introduction of narrative reporting, in addition to data, on seclusions which was contributing to the Committee’s understanding of the issues.
(4) The “Discharge from Detention Report” which had provided the Committee with useful data. Dr. Land was monitoring the issues arising from the report.
(5) The revised Hospital Managers Policy was due to be considered by the Committee at its next meeting prior to presentation to the Board for approval.

The Board also noted that the provision of summary reports to the Committee on CQC MHA inspections had been re-established and the relevant action arising from the CQC inspection of the Trust in January 2015 had, therefore, been completed.

In response to questions from the Non-Executive Directors it was noted that:

(1) The high incidence of people being taken to a police place of safety in County Durham and Darlington was attributed to presentations of violence and intoxication.

It was also noted that discussions at a recent meeting of the Safeguarding Adults Board had indicated that police officers in Cleveland were more likely to respond to behavioural issues than those in other urban areas.

(2) Under the Crisis Concordat the Trust was expected to deal with all section 136 admissions; however, its impact was not yet fully apparent as the action plan was still being implemented.

Mrs. Stanbury advised that there had been a 59% decrease in the number of people taken to a police place of safety in Teesside.

(3) The street triage services, through providing advice to the Police, were contributing to a reduction in the overall use of section 136 of the MHA.

Mrs. Stanbury advised that further training was also being provided to police officers on the provisions of the Mental Health Act.

(4) The new Crisis Services were expected to reduce the number of self-presenters at Roseberry Park.

(5) The high level of activity of the street triage service in Scarborough, which at 213 contacts in the last quarter was 3 times higher than in Teesside, was due to:

(a) The Scarborough service operating under a different service model.

A further report had been requested by Mrs. Stanbury on the implications of this.

(b) A higher number of people coming into contact with the service who lacked local support as it was a tourist destination.

Dr. Land also advised that concerns about the Deprivation of Liberty Standards remained as they had been applied 30,000 times within the first 3 months of 2015 compared to 12,000 times for the whole of 2012/13. At a national level concerns about the standards had been passed to the Law Commission, following a Parliamentary debate, and a draft bill was expected to be presented in 2016.

## 15/170 ANNUAL REPORT ON DIRECTORS' VISITS

The Board received and noted the annual report on the progress of actions arising from Directors' visits.

A summary of the issues raised during the visits together with commentary on action taken in response was appended to the report.

Mr. Kilmurray advised that:

(1) The change to the format of Directors' visits had resulted in more services being visited than previously but fewer actions were being identified.

(2) The key issue appeared to be how conversations with staff were conducted during the visits.

In response to a question Mr. Kilmurray advised that, during visits, services were asked to identify their "three wishes"; however, this information was not contained in the report and, in some cases, the issues raised had already been addressed.

The Chairman considered that it would be beneficial to include this information in future reports as it provided an indication of the issues staff considered to be important.

**Action: Mr. Kilmurray**

## 15/171 SMOKING CESSATION AND NICOTINE MANAGEMENT PROJECT

The Board received and noted a briefing paper on the smoking cessation and nicotine management project, which was being undertaken to support the implementation of the NICE PH48 "Smoking cessation in secondary care" guidance in the Trust, prior to the formal presentation of the PM3 form (business case) to the next Board meeting to be held on 23rd July 2015.

Dr. Land highlighted the extensive range of work being progressed and the key decisions which would need to be taken during the project.

In response to questions Dr. Land advised that:

(1) The Trust was in regular contact with three other Trusts which were further advanced in the implementation of the NICE guidance.

To date learning from these Trusts had highlighted the complexities of introducing smoking cessation; that different approaches had been taken on key issues (e.g. the use of e-cigarettes); and that the impact of smoking cessation, e.g. on levels of violence and aggression, had varied significantly between the Trusts.

However, despite the introduction of the guidance being challenging, he considered that the reasons for undertaking the project, in terms of the overwhelming evidence of the excess of mortality and morbidity suffered by people with severe mental illness as a result of smoking and the benefits of stopping smoking on mental health, remained strong.

(2) The risks arising from the project would be clarified as it progressed in the context of the key decisions to be taken e.g. on the use of e-cigarettes.

(3) To date the project had proved to be both more complex and more worthwhile than expected. One of the important issues identified was that, although it had been understood that courts had determined that smoking did not constitute a human right, this matter remained the subject of debate.

***Agreed** – that the implementation of the NICE PH48 smoke free guidance in secondary care be continued with a confirmed date to go smoke free on 9th March 2016.*

**Action: Dr. Land**

## 15/172 FINANCE REPORT AS AT 31ST MAY 2015

The Board received and noted the Finance Report as at 31st May 2015.

In response to questions Mr. Martin advised that:

(1) Cash flow was behind plan but there was sufficient headroom in terms of liquidity and, so long as the variance did not increase significantly during the year, no regulatory issues should arise.

(2) There had been an increase in expenditure on overtime in March and April 2015 but this appeared to be reducing. Whilst there were no concerns, at present, the issue would continue to be monitored.

(3) CRES schemes for 2015/16 were in place but it was recognised that these needed to be delivered. In addition further work was required to identify schemes for 2016/17 and 2017/18 in view of the tightening financial position nationally.

## 15/173 PERFORMANCE DASHBOARD AS AT 31ST MAY 2015

The Board received and noted the Performance Dashboard Report as at 31st May 2015.

In introducing the report Mrs. Pickering drew attention to:

(1) The presentational enhancements to the report, as requested under minute 15/44 (24/2/15), including:

(a) The use of arrows in the summary report to indicate the direction of travel on indicators over the previous three months.

(b) The provision of trend lines on the graphs.

It was noted that the trend lines were provided for 24 months rather than 3 years as stated in the report.

Board Members considered the changes made to the report to be very helpful.

(2) The slight improvement to performance on access indicators.

(3) The Trust achieving its target on “out of locality” admissions.

Mrs. Pickering advised that the trend line included in the graph looked odd as a result of the basis of the indicator being changed from actual numbers to percentages.

Board Members raised the following matters:

(1) Whether the recovery rate of IAPT services in Scarborough and Whitby raised any implications for the receipt of CQUIN income.

Mrs. Pickering advised that:

(a) The recovery rate was not a CQUIN indicator.

(b) Failure to achieve target could result in the Trust incurring financial penalties under the contract; however, none had been applied to date.

(c) An action plan had been agreed which included work to enable the Trust and Commissioners to gain an understanding of why people entering the service had a higher level of need than elsewhere as this impacted on recovery rates i.e. although patients were making significant progress they were not achieving the definition of recovery included in the contract.

(d) The Commissioners also intended to undertake some work, as part of the roll out of the next tranche of self-referral in North Yorkshire, which could result in people entering the service earlier and, thereby, improve recovery rates.

(2) The impact of the street triage services in Scarborough on referrals to the IAPT service.

In response it was noted that the street triage service and the IAPT service catered for different client groups; however, where appropriate, the street triage service could suggest that a person might benefit from IAPT services.

(3) How the downward trend on KPIs 19 and 20 (patient reported outcome measures) could be reconciled with the upward trend on KPIs 21 and 22 (clinically reported outcome measures).

Dr. Land explained that:

(a) The point at which assessments were undertaken could have an effect.

Patients entering a service could be extremely ill making it difficult to undertake a baseline assessment at that time. It was likely, in these cases, that the assessment would be delayed until the patient had commenced treatment. This tended to result in patient reported outcome measures being underscored.

In response significant work was being undertaken with services to make sure assessments were completed as soon as practicable.

(b) The approach to clustering could also impact on the indicators. There was an ongoing debate in MHSOP on whether focussing on particular clusters would provide a better indication of outcomes.

In addition Mrs. Pickering advised that the outcome tools were relatively new and services were starting to ask questions about their application.

The Non-Executive Directors highlighted the vital importance of understanding the messages provided by outcomes data.

(4) The treatment of unexpected deaths which were originally considered to result from an SUI but were subsequently found to be due to natural causes.

Mrs. Stanbury reported that, in these cases, a request would be made to the CCG to seek a downgrade to the national system and, if this change was approved, it would then be reflected in the Trust's data.

In response to questions Mrs. Stanbury advised that:

(a) Death as a result of an overdose of an illegal substance could be categorised as an SUI. However, there was a grey area where the death appeared to have been due to a heart attack but was subsequently found to be related to drug overdose.

(b) Nationally there was an increase in deaths classified as SUIs particularly for older women.

(c) The Trust was not an outlier on deaths classified as SUIs; however, there were comparatively more of these incidents in the North East than in other regions. The reasons for this were not fully understood.

**15/174 USE OF THE TRUST SEAL**

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

**15/175 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.

**15/176 DATE AND TIME OF NEXT MEETING**

It was noted that the next meeting of the Board would be held, in public, at 9.30 am on Thursday 23rd July 2015 in the Board Room, West Park Hospital, Darlington.

**15/177 CONFIDENTIAL MOTION**

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

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

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

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

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

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

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

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

Following the transaction of the confidential business the meeting concluded at 12.20 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

**ITEM 2**

**FOR GENERAL RELEASE**

**BOARD OF DIRECTORS**

**Date of Meeting:** 23rd July 2015

**Title:** Board Action Log

**Lead:** Phil Bellas, Trust Secretary

**Report for:** Information/Assurance

## This report includes/supports the following areas:

| **STRATEGIC GOALS:** | ✓ |
|---|---|
| **To provide excellent services working with the individual users of our services and their carers to promote recovery and well being** | |
| **To continuously improve the quality and value of our work** | |
| **To recruit, develop and retain a skilled and motivated workforce** | |
| **To have effective partnerships with local, national and international organisations for the benefit of our communities** | |
| **To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities** | ✓ |

| **CQC REGISTRATION: Outcomes (✓)** | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | | Staffing | | Supporting workers | |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | ✓ |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | ✓ |

# Board of Directors Action Log

**RAG Ratings:**

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

| Date | Minute No. | Action | Owner(s) | Timescale | Status |
|---|---|---|---|---|---|
| 27/05/2014 | 14/167 | Clinical work being undertaken by registered nurses to be further explored | CS | Jul-15 | See agenda item 8 |
| 27/05/2014 | 14/167 | Briefing to be provided to a Board Seminar on a "perfect day" | MB | Sep-15 | |
| 29/07/2014 | 14/233 | Further Board discussions to be held on the key factors influencing trends on unexpected deaths | MB | 2015 | |
| 30/09/2015 | 14/284 | A briefing to be provided to a Board Seminar on Equality and Diversity | MB/DL | Dec-15 | |
| 25/11/2014 | 14/358 | Proposals to be developed for addressing concerns about the provision of temporary staffing at short notice due to sickness absence | BK | Sep-15 | This action is being taken forward by the Director of Operations for County Durham and Darlington as agreed with the Joint Consultative Committee |
| 25/11/2014 | 14/358 | Future six monthly nurse staff reports to:<br>- Use bullet points instead of charts and graphs<br>- Provide assurance that complaints highlighted in the report have been addressed through usual procedures<br>- Provide complete data on fill rates | CS | July 15 | See agenda item 8 |
| 25/11/2014 | 14/358 | Next six monthly nurse staffing report, based on data up to the end of April 2015, to be provided to the Board | CS | July 15 | See agenda item 8 |
| 25/11/2014 | 14/360 | Project documentation on the implementation of the NICE public health guidance 48 (smoking cessation) to be provided to the Board | NL | July 15 | See agenda item 11 |

| Date | Minute No. | Action | Owner(s) | Timescale | Status |
|---|---|---|---|---|---|
| 27/01/2015 | 15/16 | The information contained in the Equality Data Document to be used in future business planning | SP | Oct-15 | |
| 24/02/2015 | 15/42 | Business case on the completion of the organic bed project in County Durham and Darlington to be developed | BK | Sep-15 | |
| 24/03/2015 | 15/65 | Further discussions to be held with the CQC on its approach to restrictive practices and its interpretation of the revised MH Code of Practice | MB | July 15 | |
| 24/03/2015 | 15/68 | Provision of a report on the updated culture metrics | DL | 24/11/2015 | |
| 28/04/2015 | 15/98 | Report on the range of mandatory training and levers available to increase compliance to be presented to the QuAC | DL/CS | Jul-15 | See agenda item 7 |
| 28/04/2015 | 15/99 | The Workforce Strategy Scorecard to be included in the Quarterly Workforce Reports | DL | To commence 23/07/2015 | See agenda item 15 |
| 26/05/2015 | 15/131 | The findings of the repeat study by the Clinical Audit and Effectiveness Team into staff clinical contact to be included in the next six monthly nurse staffing report | CS | Jul-15 | See agenda item 8 |
| 26/05/2015 | 15/131 | Consideration to be given to alternative approaches to responding to the continuing low fill rate for registered nurses at Springwood e.g. compensating staff for travelling | DL | Oct-15 | |
| 26/05/2015 | 15/132 | A progress report on the implementation of the waiting times action plans (including data on performance by team over time) to be presented to the Board | BK | Nov-15 | |
| 26/05/2015 | 15/133 | Future reporting of data on additional hours worked by staff to differentiate between full and part-time staff | DL | Nov-15 | |
| 26/05/2015 | 15/133 | Consideration to be given to providing greater flexibility within the Trust's 12 hour shift system as part of the Working Longer Review | DL | Mar-16 | |
| 26/05/2015 | 15/133 | Progress report on the implementation of the Trust Composite Staff Action Plan to be presented to the Board | DL | Nov-15 | |
| 26/05/2015 | 15/137 | The Annual Report and Accounts of the Charitable Trust Funds 2014/15 (as approved) to be submitted to the Charities Commission | CM | Jan-16 | |

| Date | Minute No. | Action | Owner(s) | Timescale | Status |
|---|---|---|---|---|---|
| 26/05/2015 | 15/141 | The contents of and language used in the quarterly Information Strategy and Governance Assurance Reports to be less technical | CM | From Sept 2015 | |
| 23/06/2015 | 15/162 | Data on waiting times and the number of people waiting as at 31/3/14, 30/9/14, and 31/3/15 to be provided to Board Members | SP | Jul-15 | |
| 23/06/2015 | 15/164 | The Trust's Choir to be invited to perform at the forthcoming AGM | PB | Jul-15 | |
| 23/06/2015 | 15/166 | The outcome of the review of compliance on new employees receiving equality and diversity training to be included in the next workforce report | DL | Jul-15 | See agenda item 15 |
| 23/06/2015 | 15/167 | The transposition of column headings in Appendix 1 to the nurse staffing report to be addressed | EM | Sep-15 | |
| 23/06/2015 | 15/170 | Information on the three wishes raised by teams to be included in future reports on Directors' visits | BK | Jun-16 | |

**FOR GENERAL RELEASE**

**BOARD OF DIRECTORS**

**Date of Meeting:** **Thursday 23 July 2015**

**Title:** **To consider the report of the Quality Assurance Committee**

**Lead Director:** **John Robinson, Non-Executive Director**

**Report for:** **Assurance/Information**

**This report includes/supports the following areas:**

| **STRATEGIC GOALS:** | ✓ |
|---|---|
| **To provide excellent services working with the individual users of our services and their carers to promote recovery and well being** | ✓ |
| **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 our communities** | |
| **To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities** | ✓ |

| **CQC REGISTRATION: Outcomes (✓)** | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | ✓ | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | ✓ | Meeting nutritional needs | ✓ | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | ✓ | Cleanliness and infection control | ✓ | Management of medicines | ✓ |
| Safety and suitability of premises | ✓ | Safety, availability and suitability of equipment | ✓ | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | ✓ | Staffing | | Supporting workers | |
| **Quality and management** | | | | | |
| Statement of purpose | ✓ | Assessing and monitoring quality of service provision | ✓ | Complaints | ✓ |
| Notification of death of a person who uses services | ✓ | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | ✓ |
| Records | ✓ | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | ✓ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

**BOARD OF DIRECTORS**

Date of meeting: Thursday 23 July 2015.

Title: To consider the report of the Quality Assurance Committee

## 1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting on 2 July 2015.

## 2. BACKGROUND INFORMATION

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

## 3. KEY ISSUES

3.1 The confirmed minutes from the previous meeting of the Quality and Assurance Committee held on 4 June 2015 are at Appendix 1.

Key matters arising for discussion were:

- That an update would be provided by the Trust Chief Pharmacist on the electronic prescribing project
- Exception quality scorecards should be attached to each locality report received
- That the Health, Safety & Security Framework working group reports to the Committee will include supplementary narrative on the RIDDOR section of the report.

3.2 The Committee received the bi-monthly updates from the Locality Directors of Operations around the principle risks and concerns, together with assurances and progress from Forensic Services and North Yorkshire localities.

**Forensic Services** –where key issues raised were:

- Recruitment across both FMH and FLD services with approximately 43 unfilled vacancies at the end of May 2015.
- Concerns around CRES plans to reduce staffing on nights and the impact this may have on patient and staff safety.
- The new requirement within the revised Mental Health Act Code of Practice to have 2 registered nurses to undertake observations when a patient is secluded.
- The national agenda for Learning Disabilities and the potential for bed cuts. Concerns were raised that the national leads on these services were not thoroughly briefed on local issues.

**North Yorkshire LMGB -**–where key issues raised were:

- Work around ensuring compliance with the Eliminating Mixed Sex Accommodation requirements was underway at The Friarage (Wards 14 and 15) following the CQC report recommendations.
- The need to commission a new mode of CAMHS within the locality.
- Recruitment of staff – particularly in the Harrogate, Malton and Scarborough areas.
- The long term viability of services in North Yorkshire in its current model/structure.

3.3 The Committee received key assurance or exception reports from Committee standing sub-groups or Trust lead officers and the exceptions and key issues raised from the submissions were as follows:

**Clinical Effectiveness Group** – Forensic Services highlighted the significant effect the implementation of the NICE guidance regarding the management of violence and aggression would have on the service. The guidance prohibits the use of mechanical restraints and also requires an external review

(the review group to include a service user representative) after each restrictive intervention. Based on current episodes of restraint this would mean approximately 5 reviews per day taking place.

**Health, Safety, Security and Fire Working Group Assurance Report** – the report was presented by Mr Kilmurray and contained a summary of the previous years' work of the group and the work plan for the current year.

**Patient Safety Group** – an update was provided regarding the DATIX project and it was noted that the project was planned to go live during August 2015. There continues to be a reduction in the number of DATIX reports awaiting more than 10 days for approval with this number now at 53 (131 in June 2015). There were no actions from SUI investigations that had been overdue for more than 1 month. A discussion was held about how lessons learned could be evidenced into sustainable practice changes and it was agreed that this would be considered.

**Patient Experience Group** – the Committee was informed that this Group had not met in June 2015 due to it not being quorate. It was suggested by Mrs Bessant that the Group may wish to review the frequency of its meetings to ensure appropriate attendance in future.

**Safeguarding adults and children** – The serious case review involving a 17yr old in Durham has now been completed. The case will be going to an inquest and then the LSCB will hold a media meeting for all organisations involved. There are 6 serious case reviews currently underway in Durham which may attract media attention for the LSCB due to the high numbers. Redcar LSCB has put forward a serious case review to the National Panel regarding the abuse of 3 young people.
The trial regarding the murder of an adult involved in TEWV services commenced but has since been dismissed and will be rescheduled for later in the year. There will also be a serious case review relating to this case.
There has been an increase in the number of domestic abuse cases within all areas which will impact upon the work of both the adult and children safeguarding teams.

3.4 The Committee considered the CQC registration and assurance update and it was noted that:

- MHA monitoring reports had been received for Langley and Bek wards with issues being raised regarding privacy and dignity, record keeping and CQC information not being displayed.
- Mock inspections by the Compliance Team had been carried out on Hawk Ward, Ridgeway, Ward 15 – Friarage and Cedar Ward at Harrogate.
- The challenge to the CQC regarding the rating the Trust was awarded after the recent inspection has been acknowledged and is currently being reviewed by the CCQ.
- Conformation has been received from the CQC that the acquisition of the Vale of York services will not impact on our current rating.

3.6 The Patient Safety and Patient experience report is at Appendix 2.
No key risks or trends were identified. A new report style was presented and comments for further improvements were received and noted for future reports.

**4. Workforce and Staffing Report** – the Committee received the first Workforce Staffing report. It was agreed to bring a quarterly report to future QuAC meetings – each one to look at a particular workforce staffing issue in greater detail. The next report will explore current problems around recruitment and retention, including hard to fill posts, and actions in place to address this.

**4.1 Mandatory Training Report** – it was highlighted that mandatory training was currently at 88% against the Trust target of 95%. The Committee discussed various ways of how compliance could be improved from additional e-learning to relating training performance to pay progression/ remuneration penalties. It was agreed that the Trust would need to look creatively at training models and methodology to make training more appealing to staff and also more cost effective.

**4.2 Drug & Therapeutics Report (March – June 2015)** – compliance with NICE guidance relating to physical health monitoring for 12 months by secondary care for patients on anti-psychotic medication was highlighted as a risk – this matter had also been discussed at a recent EMT meeting. The Trust is involved in influencing the design of the electronic prescribing and medicines project (EPMA) and is to act as a testing partner for the system commencing in October 2015. If successful, a business case will be drafted for full implementation across the Trust.

## 5. IMPLICATIONS/RISKS

**4.1** **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.

**4.2** **Financial:** There were no direct financial implications arising from the agenda items discussed.

**4.3** **Legal and Constitutional:** The terms of reference, reviewed annually, outline compliance requirements that are addressed by the Quality Assurance Committee. The Committee approved the declaration of CQC compliance other than the known exceptions presented in the monthly report.

**4.4** **Equality and Diversity:** The QuaC is supported in the delivery of its key objectives by a structure of working groups one of which is the Equality and Diversity Steering Group. The committee receives quarterly assurance reports from each of the working groups.

## 5. CONCLUSIONS

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

## 9. RECOMMENDATIONS

That the Board of Directors note the issues raised at the QuAC meeting, held on 2 July 2015 and to note the confirmed minutes of the meeting held on 4 June 2015, (appendix 1).

**Hugh Griffiths, Non-Executive Director**

**Appendix 1 Confirmed minutes of meeting held on 4 June 2015**
**Appendix 2 Quality Data report**

**Appendix 1**

# MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 4 JUNE 2015, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON

**Present:**
Mr John Robinson, Chairman
Mrs Lesley Bessant, Chairman of the Trust
Mr Martin Barkley, Chief Executive
Dr Hugh Griffiths, Non-Executive Director
Mr Brent Kilmurray, Chief Operating Officer
Dr Nick Land, Medical Director
Mrs Chris Stanbury, Director of Nursing & Governance
Mr Jim Tucker, Non-Executive Director

**In attendance:**
Mrs Jennifer Illingworth, Director of Quality Governance
Mr David Brown, Director of Operations, Teesside, (for minute 15/97)
Dr Lenny Cornwall, Deputy Medical Director, Teesside
Ms Christine McCann, Associate Director of Nursing, (for minutes 15/100 and 15/102)
Mrs Sharon Pickering, Director of Planning and Performance
Mr Stephen Scorer, Deputy Director of Nursing
Dr Paul Tiffin, (for minute 15/105)
Mrs Donna Oliver, Deputy Trust Secretary
Dr Sarah Dexter-Smith, Professional Lead, MHSOP Psychology

Connor McPhillips, Samantha Moore, Claire Morgan, Samantha Palfreeman and Bethany Parry – Students, University of Teesside

**15/93 APOLOGIES FOR ABSENCE**

Apologies for absence were received from:
Mr David Jennings, Non-Executive Director
Mr Paul Newton, Director of Operations, Durham and Darlington
Dr Ingrid Whitton, Deputy Medical Director, Durham and Darlington

It was noted that the Directors of Operations for North Yorkshire and Forensic Services were not required to attend the meeting.

**15/94 MINUTES OF PREVIOUS MEETING**

***Agreed*** *- that the minutes of the meeting held on 7 May 2015 be approved as the correct record and signed by the Chairman.*

**15/95 ACTION LOG**

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

The following updates were noted:

*14/201* *LMGB reports to QuAC – October 2014 to include narrative on metrics compliance rated red.*

This matter was dealt with under minute 15/96 below.

*15/8* *Further discussion to be held on Investing in Children publication (October 2014) by D&D LMGB.*

This matter was dealt with under minute 15/96 below.

*15/11* *Suicide Prevention Project.*

It was noted that this project has now been integrated with the proposed clinical risk and harm minimisation project.

*15/51 (6)* *An analysis of the amount of time spent in various restraint holds to be undertaken and fed back through the County Durham and Darlington LMGB report.*

This matter was dealt with under minute 15/96 below.

*15/52 (b)* *The number of staff remaining to receive training in suicide prevention to be established and fed back via the Tees LMGB report.*

This matter was dealt with under minute 15/97 below.

*15/63* *Briefing gap analysis on prosecutable regulations to be provided to EMT to aid discussions on further evidence/processes to be put in place.*

This had been included in the briefing under fundamental standards.

*15/73 (4)* *The staffing report due to go to June QuAC meeting should be deferred to July 2015.*

Mrs Stanbury clarified that there were 2 separate reports. The Workforce/Staffing Report would be presented to the July 2015 QuAC meeting and the Nursing Staffing Report would go to the Board of Directors in July 2015.

*15/73 (5)* *A request would be made to Ramptons to undertake a review of the physical environment at Ridgeway.*

Some initial approaches had been made to Ramptons to see if they would be willing to undertake a review of the physical environment at Ridgeway given ongoing concerns regarding fixtures and fittings and build quality. An update would be fed back as part of the next locality report to QuAC.

**15/96 DURHAM & DARLINGTON LMGB ASSURANCE/EXCEPTION REPORT**

The Committee received and noted the Durham and Darlington LMGB Assurance/Exception report.

Mr Kilmurray on behalf of Mr Newton asked Committee members for any queries on the report:

The following queries were noted:

(1) Issues with Model lines and rolling out Local Authority support for the model remained an issue, with concerns around the approach and volume of work.

This was in relation to the South Durham psychosis team, which was rolling out model lines in County Durham with internal teams consisting of social care and local authority staff working together. There were potentially tensions between the 2 systems when rolling out the care documentation. Ongoing discussions were taking place with the local authority staff to resolve the issues in order to promote better partnership working. A meeting was scheduled during the week commencing 8th June 2015 to look at these matters in more detail and to seek to develop a solution.

(2) The lessons learned and actions to address the issues from SUIs in March 2015 in AMH Durham and Darlington would be brought back to the Committee.
**Action: Mr B Kilmurray**

**15/97 TEES LMGB ASSURANCE/EXCEPTION REPORT**

The Committee received and noted the Tees Locality Management and Governance Assurance/Exception Report.

In response to a query raised at the May QuAC meeting, it was noted that suicide prevention training had been delivered to 78% (131) of qualified staff.

Mr Brown highlighted the following from the various services:

**(1) Adult Mental Health (AMH)**

a) There were currently 32 vacant beds across the wards, (not including PICU or rehab) and occupancy had been reducing for some time. This would provide an opportunity for giving older people the choice of single sex wards or a ward with older people.
b) The inpatient medical workforce on Tees were being reconfigured to address the high spend on medical agency staff. The first phase of this pilot would seek to reduce locum cover in the PICU from 2 to 1 and subsequently to remove the need for this by Quarter 3.
c) There had been 3 deaths in the month of April 2015, 2 of which related to physical health problems.
d) Redcar and Cleveland Access Team was an outlier for Quarter 4 with the Friends and Family Test survey, which was due to 2 members of staff not following processes. More clear guidance had been given to this small team.
e) An improvement notice had been received from Commissioners in relation to waiting times and recovery.

**(2) Mental Health Services for Older People (MHSOP)**

a) Out of locality admissions had reduced from 17 to 7 during April 2015, which had been due to an overall 40% reduction in admissions. This had come down from a position where there had been 5 admissions in 5 days.

The nursing home in Hartlepool currently subject to CQC action would now be closing. This would create problems accessing home placements for people with dementia and challenging behaviour in the future.
b) Red compliance issues around audit on Nutrition Support with issues around timeliness of completing the MUST assessment tool. Modern matrons were addressing this matter.

**(3) Children and Young Peoples Service (CYPS)**

a) Waiting times had been above 9 weeks for Targeted Services in Stockton and Hartlepool; however posts had now been recruited to and the backlog of work was starting to reduce.
b) Initial feedback had been positive on referrals from Middlesbrough being passed through a single point of access to enable screening through safeguarding.
c) Waiting times were above the expected level with referrals at double the expected rate.

**(4) Learning Disabilities (LD)**

a) The Thornaby Road action plan had been reviewed and most actions were now completed.
b) There had been provider failures within the third sector for LD services. A recent situation had occurred where a patient could not be accommodated due to their requirements for a bespoke package of care.

Thought would need to be given to the future expectations on LD services with a view to potential reconfiguration due to the needs for patients requiring individual places for care.

Arising from discussion it was noted that:
(1) The changes around the reduction in bed occupancy had been due to a variety of different factors, including the Accommodation Officer, rehabilitation services taking and treating people more quickly and the Blue Light protocol for speedy discharge. A lot of the quality improvement work had led to the services being able to discharge patients more quickly, especially those with personality disorders.
(2) Length of stay was a factor for Middlesbrough, especially for substance misuse patients.
(3) The mother of a patient had requested CCTV footage of her son, who she believed had been assaulted, through PALS

Further to the viewing of the CCTV footage all allegations had been dropped.

The use of CCTV was proving beneficial to the Trust in providing assurance and evidence.

(4) There was no Trust policy around the use of CCTV; however, there was the 'privacy notice' guidance. This provided guidelines on the usage of CCTV which was for observational and teaching purposes.
(5) Following the decision on redeployment the CYPS dietician post would now proceed to advertisement.
(6) The security issues around Redcar were due to drunk and disorderly behaviour and substance taking outside the premises and the police were going to install CCTV.
(7) There was no standard tracking system across the Trust for concerns raised and resolved locally. This be addressed as part of the implementation of the DATIX system.
(8) Within MHSOP there appeared to be inconsistency with the admission data.

Mr Brown confirmed that that there had been a reduction from 17 to 7 admissions.

Members of the Committee considered that it would be helpful for the Locality's risk register to be appended to their Assurance/Exception reports.

***Agreed**: that Locality risk registers be provided to the Committee as part of the LMGB assurance and exception reports from* August 2015.

**Action: All Directors of Opreations**

(Note: Mr. Brown undertook to circulate a copy of the Tees Locality Risk Register to Members of the Committee in the meantime).

**15/98 TRUST QUALITY SCORECARD 2015/16**

The Committee received and noted the Trust Quality Scorecard for 2015/16.

Mrs Pickering highlighted the following matters:

(1) That the annual position had also been provided within the report to enable comparison with the baseline for 2013/14.
(2) Out of the 26 indicators reported in the Scorecard, the Trust's outturn position for 2014/15 had shown an improvement on 10, out of 22, of the indicators.
(3) Comparing the performance across localities, it was interesting to note that areas were performing at consistently similar levels, with Teesside slightly over performing against others.
(4) The significant red rated indicators at Quarter 4 related to:
    (a) Patient choice for outpatient appointment.
    (b) Appointments cancelled by the Trust.
    (c) Reduction in copies of care plans given to patients.
    (d) Mean level of Improvement for clinical outcomes for MHSOP patients.
    (e) Lowest position for the year for level of improvement in SWEMWBS (MHSOP only).
    (f) Audit compliance with NICE guidelines, with an annual outturn position of 9.09% against a target of 85%. Only 1 audit out of 11 was fully compliant during the year.
    (g) Teams with staffing levels 20% or 2 WTE (whichever is the highest) lower than plan.
    (h) Mandatory and statutory training.
    (i) Staff with current appraisals, which was 13.18% below target.
    (j) Number of level 3 and above self-harm incidents.

**15/99 CLINICAL EFFECTIVENESS GROUP ASSURANCE REPORT**

The Committee received and noted the Assurance Report of the Clinical Effectiveness Group.

Arising from the report:

(1) It was highlighted that:
    (a) A report had been received on specialist services clinical supervision for Quarter 4. This showed underperformance in Forensic Services and the Directorate had been tasked with improving this position and reporting progress.
    (b) The Group had reviewed the key performance indicators and had agreed that there was potential to rationalise these further. These would be finalised during June 2015.

(2) The following key issues were noted:

(a) Within LD services work would need to be undertaken to develop appropriate PROMS and CROMS for routine use.

(b) Following a detailed review of the baseline assessment tool, the implementation of CG192 Antenatal and Postnatal Mental Health would be incorporated in the "comorbid" discussion.

**15/100 ESSENTIAL STANDARDS PATIENT & CARER REFERENCE GROUP**

The Committee received and noted the Essential Standards Patient & Carer Reference Group report including the unconfirmed minutes of its meeting held on 30 April 2015.

Ms McCann highlighted the following key issues:

(1) The name of the Group would be changed to the "Fundamental Standards Patient and Carer Group" in line with new standards set out in of the Health and Social Care Act 2010. New terms of reference had been devised and PALS had been removed from its membership.

(2) The newly formed Group would also take on responsibility for the Trust's Patient Information Steering Group.

Assurance was given that the Group would continue with unannounced visits to wards and teams throughout the Trust during 2015.

**15/101 PATIENT SAFETY GROUP ASSURANCE REPORT**

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

The following areas were highlighted:

(1) The number of outstanding DATIX reports had continued to reduce. 55 of the 131 outstanding actions had been awaiting final approval for 10 or more days.

(2) The patient safety team was working closely with the DATIX project team, acknowledging that there was some concerns about the project and process changes. There was still a considerable amount of work to be done in this area.

(3) The Patient Safety Group had asked for consideration to be given to the supervision policy work, being led by Craig Hill, and to re-visit the aims and requirements of this work.

Mrs Stanbury confirmed that the revised Supervision Policy would be presented to the EMT on 10 June 2015.

(4) A further Kaizen on incident management would take place in June 2015, following the first event on 13 March 2015.

Key risks identified were:

(1) The Patient Safety Incident Team was concerned that the number of SUI reviews in IAPT services reflected the changing presentation of patients for which the service had not been designed. There might be insufficient resource in the Patient Safety Incident Team to manage the IAPT SUI review.

IAPT services had been set up initially for patients with mild to moderate depression and therefore the systems around IAPT were much lighter in terms of risk assessment; however, people coming into these services were now more ill. This had been fed back into discussions on Teesside.

Dr Land agreed to have "off the record" discussions with other providers to see if the Trust stood as an outlier. If the service was to add 20 to 30 minutes onto the assessment process for patients that would be to the detriment of other patients.

(2) There had been an increase in suicides in MHSOP and extensive educational and training work was underway. The Group would monitor this increase and look for assurances from the training given to staff.

Assurance was provided that:

(a) There were no overdue actions arising from Serious Untoward Incidents in 2014, with only 1 action being over the 1 month deadline. A recent external audit report had given assurance that operational services were completing actions.
(b) The Patient Safety Team would continue to monitor action plans from any independent reviews, of which there had been 5 in the last 3 years.

**15/102 PATIENT EXPERIENCE GROUP ASSURANCE REPORT**

The Committee received and noted the Patient Experience Group assurance report.

Ms McCann highlighted the following matters:

(1) There were concerns over the Quality Scorecard increased trajectories on KPI 1 (overall rating of care) and 8 (complaints target), which were not achieved during 2014/15.
(2) That prioritisation should be given to the request from RADA for changes around the recording of care plans being given to patients on PARIS (KPI 5). This would involve changing the current tick box with a mandatory drop down field for completion.
(3) Work was ongoing to find solutions to recording cancelled appointments and the recording of care plans being given to patients and/or carers.

**15/103 SAFEGUARDING CHILDREN ASSURANCE REPORT**

Mrs Stanbury, on behalf of Mrs Agar, provided a verbal update on safeguarding children issues.

It was noted that:
(1) The serious case review for Hartlepool had been deferred until approximately September 2015 following the court case. This was due to start during the week commencing 8th June 2015.
(2) There was 1 SI with regard to the serious sexual allegation of assault against a minor.

**15/104 SAFEGUARDING ADULTS ASSURANCE REPORT**

Mrs Stanbury, on behalf of Mrs Agar provided a verbal update on safeguarding adult issues.

It was noted that the homicide report had been published on 'Mr S' on 28 May 2015.

There had been some interesting comments via social media, including neighbours of 'Mr S', supporting the Trust by stating that mental health services should not be blamed for the actions of this person. 'Mr.S' had gone to prison and had not entered a plea of diminished responsibility.
Arising from discussion it was noted that NHS England, under its new guidelines of standard practice, would be holding press conferences on such matters.

It was felt that the Committee should respond to NHS England and its decision to promote press involvement.

***Agreed:*** *that the key leads, both locally and nationally, at NHS England be contacted with regard to the organisation's decision to promote press involvement.*
**Action: Mrs Illingworth**

**15/105 RESEARCH GOVERNANCE GROUP ASSURANCE REPORT**

The Committee received and noted the Research Governance Group Assurance Report, together with the minutes from the meeting held on 19 March 2015.

Arising from the report it was noted that:

(1) Approval had been given to 6 new large scale National Institute of Health Research (NIHR) Portfolio studies and 18 new local Trust, non-portfolio studies.
(2) Additional metrics would be designed, as part of the Trust's new R&D strategy, which would monitor R&D progress and achievement. The current metric was the number of peer reviewed publications by Trust staff in each quarter which had been 10 at Quarter 4.

Dr Griffiths asked how the Trust closed the loop on research and development and how the outcome of research positively impacts on any service developments.

In relation to this matter it was noted that:

(a) The Trust's R&D Strategy was currently being refreshed.

(b) Any research publications were counted and reported to the Clinical Research Network.

(c) There would always be difficulties getting research out to the "coal face" of any organisation; however, there was some positive work under way in the Trust around having "informationists" attached to teams. The Librarian was leading this work.

Dr Dexter-Smith made reference to some research work that linked back into the clinical pathway and gave the example of using outcomes from the research programme to directly influence clinical practice.

The work that had been led by Mr Dave Ekers on behavioural activation had then integrated that approach, as a core part of the affective disorders framework in MHSOP and training was now planned for all staff across professions.

(3) There were concerns around the potential for reduced funding by the Clinical Research Network (CRN) for 2016/17, if recruitment remained at a low level.

In the current year the CRN allocation had reduced by 5%, as a result of reduced recruitment. Trust led large scale external research grants, led by clinicians or linked academics, would attract new research studies into the Trust.

**15/106 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS ASSURANCE REPORT**

The Committee noted the CQC Compliance update, which had been tabled at the meeting.

The report included:
Appendix 1 – The final CQC table of Draft Ratings following the inspection in January 2015
Appendix 2 - The Intelligent Monitoring Report
Appendix 3 – The CQC Mental Health Act (MHA) visit feedback summary report, 1 January 2015 – 31 March 2015.

Arising from the report it was noted that:

(1) The MHA feedback would in future be amalgamated into the CQC Compliance Report.

(2) The summaries of MHA inspections would now be reported to QuAC, since there were compliance requirements with the Mental Health Act. Guidance on how this would work was awaited but it was known that several wards had compliance issues which had been raised several times.

In response to questions it was noted that:

(1) The Trust had received a rating of "requires improvement" for the question "Are services safe?" due to an issue about privacy and dignity and same sex accommodation in a rehabilitation ward.

Mrs Stanbury explained that, post review, the Trust had requested a rating review, due to the proportionality of the findings for an organisation the size of TEWV, with many core services. It was felt that the rating process placed large Trusts at a disadvantage.

(2) In the incident monitoring report one of the identified elevated risks for the Trust had been around the number of deaths of patients detained under the Mental Health Act.

This appeared to be related to the increase in the number of older people detained under the Act who had then died of national causes. This appeared to be a similar position to other Trusts.

The same problems occurred when looking at the thresholds for 'snap shots of whistle blowing alerts received by the CQC' and 'patients that died following injury or self-harm within 3 days of being admitted to acute hospital beds', which were set at 0.

(3) On a positive note for the Trust there were only these 3 areas of elevated risk.

**15/107 PATIENT SAFETY & PATIENT EXPERIENCE DATA REPORT**

The Committee received and noted the Patient Safety and Patient Experience Data report for April 2015.

It was noted that this report would come to the July QuAC meeting in its new format with narrative and schematic analysis around level 3 and 4 incidents, PALS, complaints, SUIs and the use of control, restraint and seclusion.

**15/108 EXCEPTION REPORTING (LMGBs, QAC sub groups)**

No issues were raised.

**15/109 ANY MATTERS ARISING TO BE ESCALATED TO THE BOARD OF DIRECTORS, AUDIT COMMITTEE, INVESTMENT COMMITTEE OR TO THE CLINICAL LEADERSHIP BOARD**

There were no matters arising.

**15/110 ANY OTHER BUSINESS**

There was no other business to note.

**15/111 DATE AND TIME OF NEXT MEETING:**

The next meeting of the Quality Assurance Committee will be held on Thursday 2 July 2015, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

Email to Donna Oliver donnaoliver1@nhs.net

The meeting concluded at 3.30pm

**……..**

**Mr John Robinson**
**Chairman**
**2 July 2015**

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

# Quality Assurance Committee (QuAC)

# Patient Safety and Patient Experience Data Report

## Reporting Period:

## 01/05/2015 to 31/05/2015

making a difference together

# Tees, Esk and Wear Valleys NHS Foundation Trust
# Quality Assurance Committee (QuAC) -
# Patient Safety and Patient Experience Data Report
# 01/05/15 to 31/05/15

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**Patient Safety and Patient Experience Data Report**
**01/05/15 to 31/05/15**
**SECTION 1 – EXECUTIVE SUMMARY**

## 1.0 Executive Summary

### 1.1 Introduction

The purpose of this report is to inform the Quality Assurance Committee (QuAC) of the current levels of performance for the period of 1st to 31st May 2015.

The Trusts quality dashboard provides a high level overview of performance across the financial year of 2015/16 and utilises a number of quality indicators within the Trust. The dashboard provides assurance and highlights any areas that may require escalation to the Board. Discussion and agreement is required to ascertain whether a RAG rated status could be applied to the dashboard which would then enable exception reporting that focuses on any underperforming metrics.

An explanation of each quality metric has been provided within the exception reporting section of this report. Future reports could focus on the underperforming metrics utilising the RAG rated status within the quality dashboard.

This report will continue to be developed during the financial year 2015/16 ensuring that the report meets the needs of the Quality Assurance Committee

### 1.2 Summary of Performance

This report focuses on the period of 1st to 31st May 2015 with the following items categorised as 'red' or 'amber':

- There were 5 serious untoward incidents
- There were 10 level 4 incidents
- There were 44 level 3 incidents (self-harm only)
- There were 9 complaints
- There were 88 PALS
- There were 312 use of control and restraint
- There were 2 seclusions

### 1.3 Significant Risk

No significant risks have been identified in relation to:

- Serious untoward incidents
- Level 4 incidents
- Level 3 incidents (self-harm only)
- Complaints
- PALS
- Use of control and restraint
- Seclusions

## 1.4 Recommendations

The Quality Assurance Committee are asked to:

- Receive assurance on the overall achievement on quality and performance indicators
- Feedback on the narrative style report including any areas of development would be appreciated to ensure that the report meets the needs of the QuAC group.
- RAG rating status needs to be defined in terms of the targets to be used for future reports. This would aid the identification of specific issues to the Trust and enable more focussed exception reporting.
- Agreement as to whether the locality graphs are required in future reports.
- Discussion is required in terms of how issues or risks will be identified from this report and incorporated onto the Trusts risk register.

**Joanne Salvin**
**Quality Data Manager**
**June 2015**

**Emma Haimes**
**Head of Quality Data**
**June 2015**

## 2.0 Quality Dashboard

The quality metrics have been defined as a single dashboard providing at a 'glance' a summary of performance across the Trust.

The table below provides the number of occasions that each metric has been triggered on a monthly basis across the financial year 2015/16. A RAG rated status could be applied to the dashboard which would highlight any areas of concern.

| | 2015 - 2016 | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | April | May | June | July | August | September | October | November | December | January | February | March | YTD |
| Serious Untoward Incidents Raised | 9 | 5 | | | | | | | | | | | 14 |
| Level 4 Incidents | 13 | 10 | | | | | | | | | | | 23 |
| Level 3 Incidents (Self Harm Only) | 45 | 44 | | | | | | | | | | | 89 |
| Complaints | 26 | 9 | | | | | | | | | | | 35 |
| PALS | 81 | 88 | | | | | | | | | | | 169 |
| Use of Control and Restraint | 419 | 312 | | | | | | | | | | | 731 |
| Seclusions | 10 | 2 | | | | | | | | | | | 10 |

If a RAG rated status were to be used the table below could be used to track the number of metrics that were classified as either 'red', 'amber' or 'green on a monthly basis across the financial year and a trend on the previous month as illustrated below:

| | April | May | June | July | August | September | October | November | December | January | February | March | Trend on Previous Month |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Red | | | | | | | | | | | | | - |
| Amber | | | | | | | | | | | | | - |
| Green | | | | | | | | | | | | | - |

The detail exception reporting can be found in section 3 of this report.

## 3.0 Exception Reporting

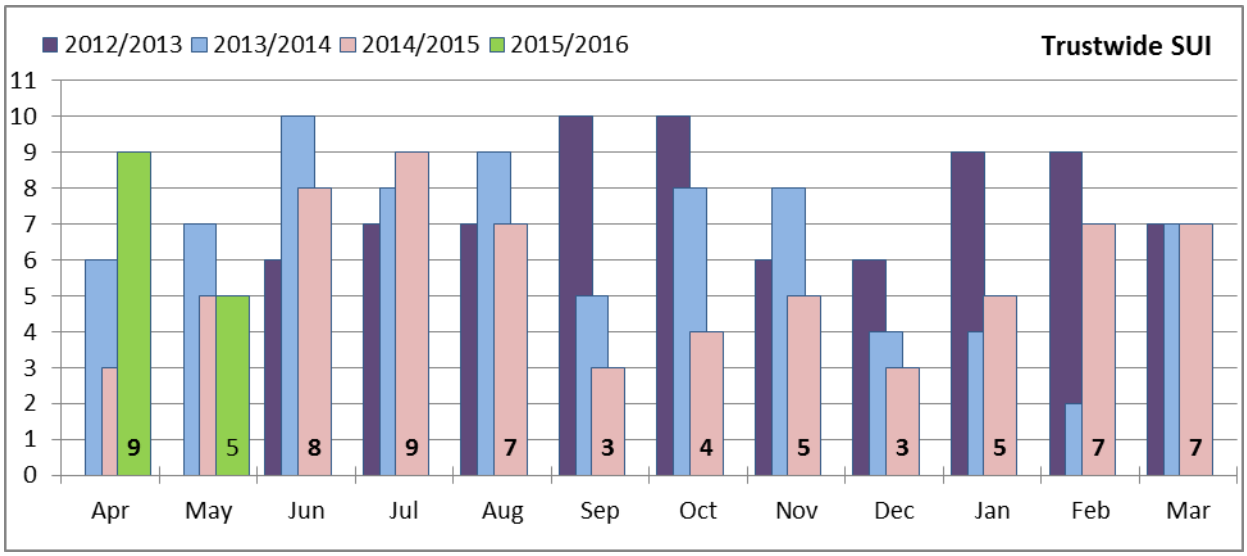
Further analysis is provided within this section of the report for all metrics identified within the quality dashboard. If a RAG rated status was applied this section could focus on any underperforming metrics i.e. those rated as either 'red' or 'amber'.

Detailed exception reports are provided for:-

- Serious Untoward Incidents
- Level 4 incidents
- Level 3 incidents (Self Harm Only)
- Complaints
- PALS
- Use of control and restraint
- Seclusions

## 3.1 Serious Untoward Incidents

During the reporting period there were 5 serious untoward incidents across the Trust which was a reduction of 4 on the previous month. 4 of which were classified as 'unexpected deaths (outpatient)' and 1 was classified as 'unexpected deaths (inpatient). The trend over the last 36 months can be shown as follows:




The table below shows which locality the 5 serious untoward incidents have occurred and the trend on the previous month:

| Locality | Total number of SUI's | Trend on previous month |
|---|---|---|
| North Yorkshire | 2 | 3 ↓ |
| Durham and Darlington | 2 | 3 ↓ |
| Teesside | 1 | 3 ↓ |

| | | |
|---|---|---|
| Forensic | 0 | - |

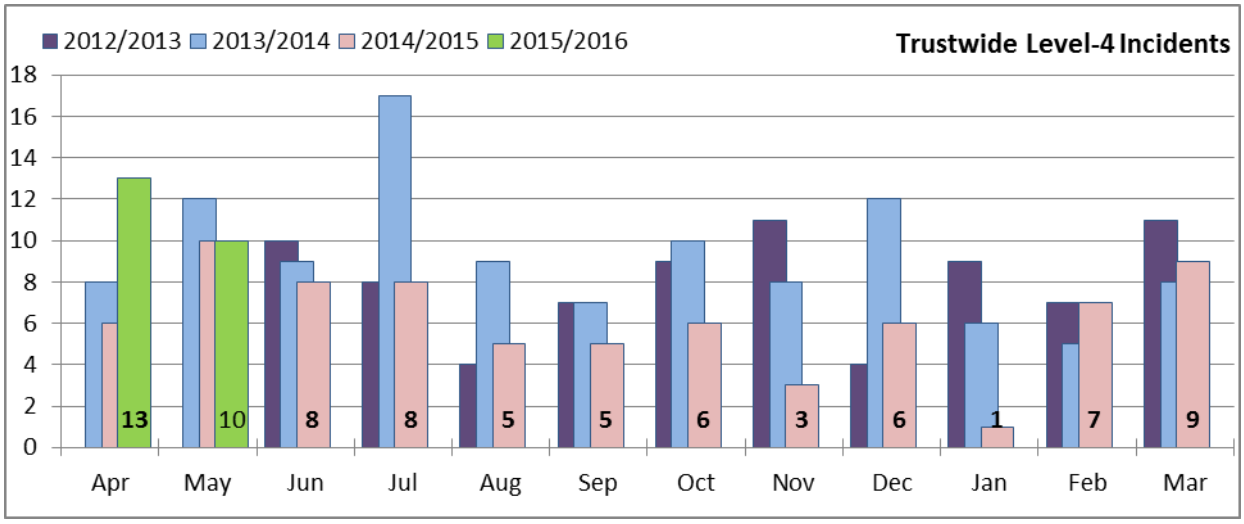
The table below shows which ward or team the serious untoward incidents have occurred:

| Total No. | Locality | Service | Ward / Team |
|---|---|---|---|
| 2 | North Yorkshire | AMH | AMH Harrogate Community |
| | | AMH | AMH Ayckbourn Unit Esk Ward |
| 2 | Durham & Darlington | AMH | AMH Derwentside and Chester-Le-Street Access |
| | | AMH | AMH Derwentside and Chester-le-Street Psychosis |
| 1 | Teesside | AMH | AMH Stockton Psychosis |

## 3.2 Level 4 Incidents

During the reporting period there were a total of 10 level 4 incidents which occurred this is a reduction of 3 on the previous month.

The trend over the last 36 months is illustrated as follows:




The table below shows which locality the 10 incidents have occurred and the trend on the previous month:

| Locality | Total number of incidents | Trend on previous month |
|---|---|---|
| North Yorkshire | 4 | 1 ↑ |
| Durham and Darlington | 2 | 6 ↓ |
| Forensic | 2 | 5 ↓ |
| Teesside | 2 | 1 ↑ |

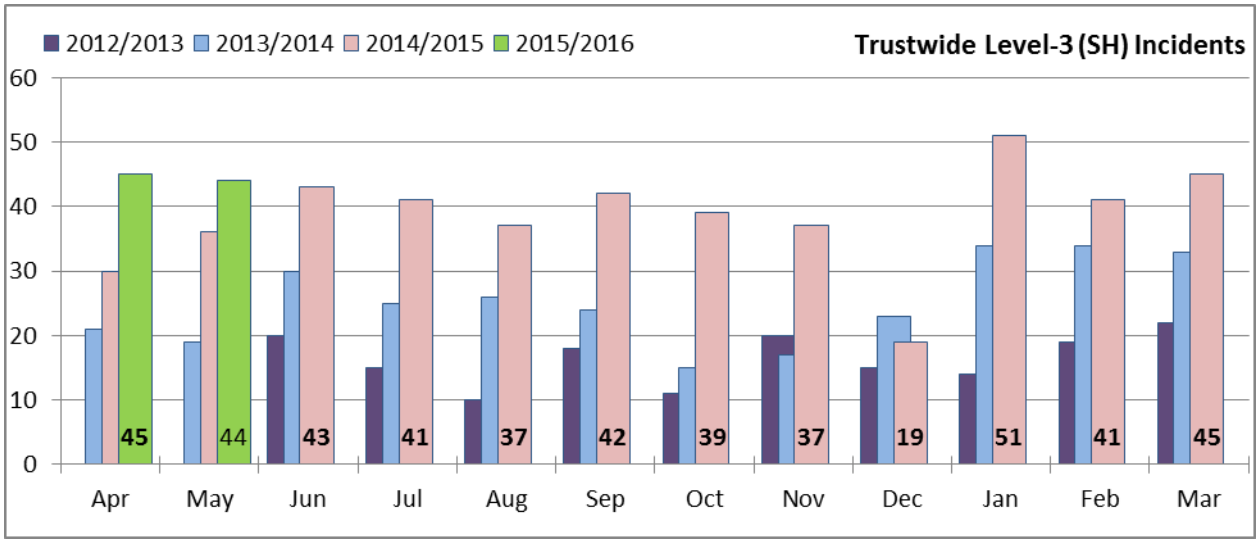
The incident categories used to define the level 4 incidents are as follows:

| Number of Incidents | Category | Wards / Team |
|---|---|---|
| 6 | Self-Harm | AMH West Park Hospital Spruce |
| | | MHSOP Scarborough Cross Lane Rowan Lea |
| | | AMH Hambleton and Richmondshire East Community |
| | | CAMHS Harrogate |
| | | MHSOP North Tees Liaison Psychiatry |
| | | AMH Bilsdale Ward |
| 1 | Assault on Patient | MHSOP Picktree Ward |
| 1 | Assault on Staff | FLD Ivy Ward |
| 1 | Inappropriate Behaviour | FMH Kirkdale Ward |
| 1 | Unexpected Death (Outpatient) | AMH Hambleton and Richmondshire East Community |

### 3.3 Level 3 (Self Harm) Incidents

There have been 44 incidents categorised as level 3 within the reporting period. This is a reduction of 1 incident from the previous month.

The graph below shows the number of level 3 incidents that have occurred by month covering a 36 month period:




The table below shows the total number of level 3 incidents within each locality and the trend on the previous month:

| Locality | Total number of incidents | Trend on previous month |
|---|---|---|
| Durham and Darlington | 20 | 23 ↓ |
| North Yorkshire | 10 | 10 - |
| Teesside | 11 | 7 ↑ |
| Forensic | 3 | 5 ↓ |

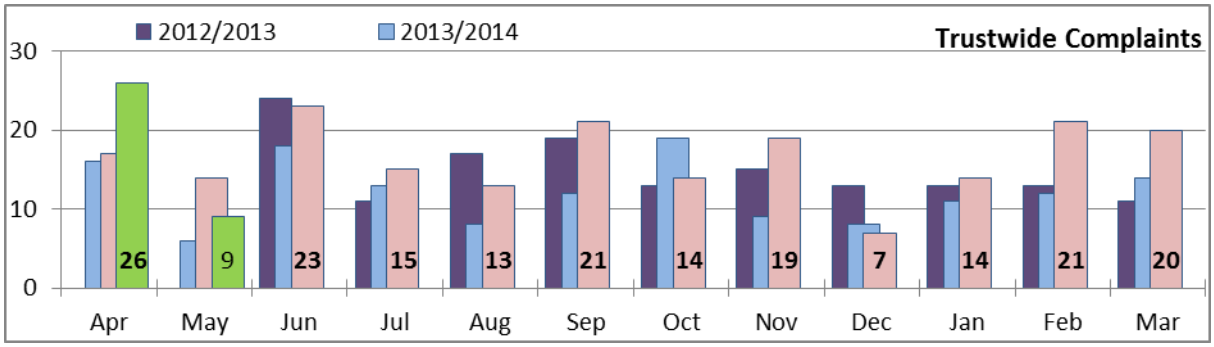
The level 3 incidents that have occurred during the reporting period were categorised as follows:

- 38 x Actual self harm
- 4 x Attempted or suspected attempted suicide
- 1 x Attempted self harm
- 1 x Drug abuse

## 3.4 Complaints

There have been a total of 9 complaints raised in the reporting period which is a reduction of 17 on the previous month.

The total number of complaints raised over the last 36 months is as follows:




The complaints that have been raised during the reporting period can be categorised into 4 areas as follows:

- Clinical Care (5)
- Attitude (1)
- Communication (1)
- Environment (2)

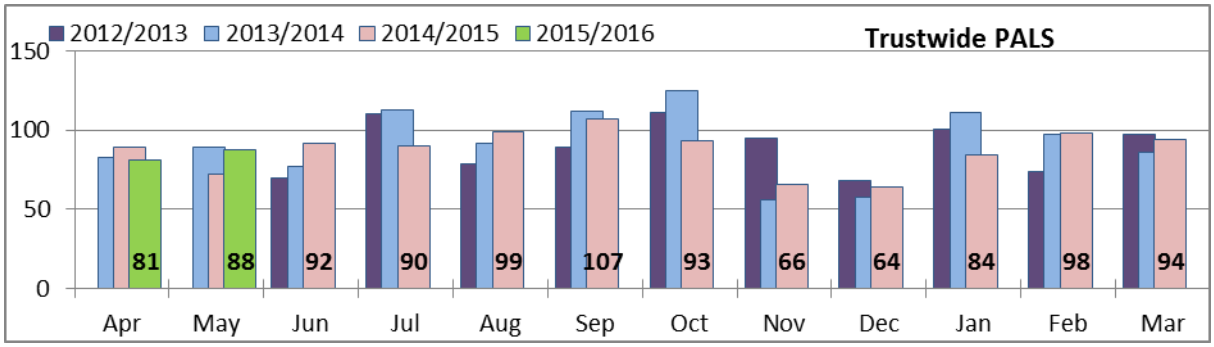
The complaints were raised in the following localities:

| Locality | Total number of complaints | Categories of complaints | Trend on previous month |
|---|---|---|---|
| North Yorkshire | 1 | Clinical care | 9 ↓ |
| Durham & Darlington | 1 | Clinical care | 5 ↓ |
| | 1 | Communication | |
| Teesside | 3 | Clinical care | 5 ↓ |
| | 1 | Attitude | |
| | 1 | Environment | |
| Forensic | 1 | Environment | 1 ↓ |

## 3.5 PALS

During the reporting period there have been 88 PALS related issues which is an increase of 7 on the previous month.

The graph below shows the trend over the last 36 months:




The table below shows the reasons given for raising a PALS issue and the trend on the previous month:

| Category | Number of Issues | Trend on previous Month |
|---|---|---|
| Clinical Care | 42 | 44 ↓ |
| General Advice | 14 | 15 ↓ |
| Attitude | 11 | 6 ↑ |
| Sign Posting | 11 | 6 ↑ |
| Environment | 4 | 3 ↑ |
| Communication | 3 | 2 ↑ |
| Staff Compliments | 3 | 0 ↑ |

PALS were raised in the following areas and categorised as follows:

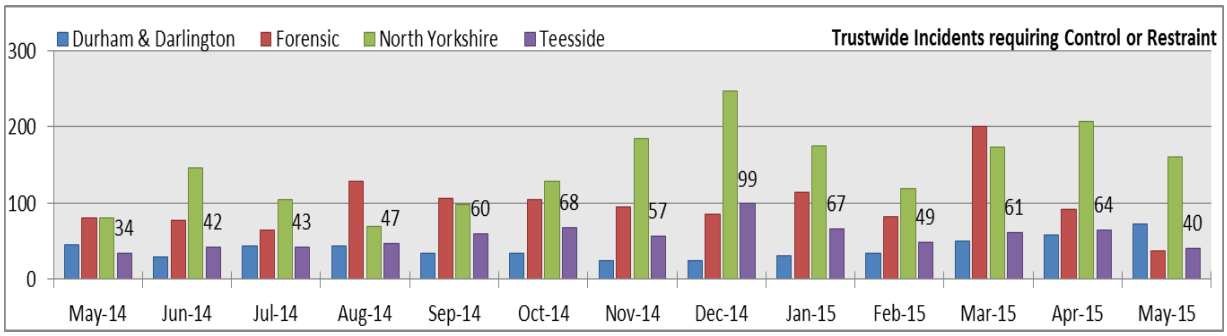
| Locality | Total number of Issues | Categories of Issues | Trend on Previous Month |
|---|---|---|---|
| Durham & Darlington<br>*24 issues raised* | 16 | Clinical care | 12 ↑ |
| | 3 | General Advice | 2 ↑ |
| | 2 | Attitude | 0 ↑ |
| | 1 | Environment | 2 ↓ |
| | 1 | Communication | 0 ↑ |
| | 1 | Signposting | 0 ↑ |
| Teesside<br>*18 issues raised* | 10 | Clinical care | 12 ↓ |
| | 3 | Attitude | 1 ↑ |
| | 2 | General advice | 2 - |
| | 1 | Communication | 1 - |
| | 1 | Staff compliments | 0 ↑ |
| | 1 | Environment | 0 ↑ |
| Forensic<br>*17 issues raised* | 9 | Clinical care | 8 ↑ |
| | 4 | Attitude | 4 - |
| | 2 | General advice | 3 ↓ |
| | 2 | Environment | 0 ↑ |

| Locality | Total number of Issues | Categories of Issues | Trend on Previous Month |
|---|---|---|---|
| North Yorkshire<br>*9 issues raised* | 4 | Clinical care | 8 ↓ |
| | 2 | Attitude | 1 ↑ |
| | 2 | Staff compliments | 0 ↑ |
| | 1 | General advice | 3 ↓ |

### 3.6 Control and Restraint

During the reporting period there have been a total of 312 incidents that required control and restraint which is a reduction of 107 on the previous month.

A 12 month breakdown of the number of incidents requiring control and restraint can be found as follows:




In May 2015 the number of incidents requiring control and restraint by locality is as follows:

| Locality | Total number of incidents | Total controls or restraint used | Trend on previous month |
|---|---|---|---|
| Forensic | 38 | 66 | 91 ↓ |
| North Yorkshire | 161 | 298 | 206 ↓ |
| Teesside | 40 | 61 | 64 ↓ |
| Durham & Darlington | 73 | 102 | 58 ↑ |

The top five reasons for control or restraint used per locality is as follows:

| | Durham & Darlington | Forensic | North Yorkshire | Teesside |
|---|---|---|---|---|
| 1 | Violence & Aggression (towards staff) ***60 incidents*** | Violence & Aggression (towards staff) ***21 incidents*** | Self-harming behaviour ***73 incidents*** | Violence & aggression (towards staff) ***21 incidents*** |
| 2 | Self-harming behaviour ***6 incidents*** | Violence & aggression (towards patient) ***7 incidents*** | Violence & aggression (towards staff) ***64 incidents*** | Self-harming behaviour ***11 incidents*** |
| 3 | Violence & aggression (towards patient) ***4 incidents*** | Self-harming behaviour ***5 incidents*** | AWOL (escape and abscond) ***6 incidents*** | Violence & aggression (towards patient) ***5 incidents*** |
| 4 | AWOL (Escape & Abscond) ***3 incidents*** | Near Miss ***2 incidents*** | Violence & aggression (towards patient) ***4 incidents*** | AWOL (escape and abscond) ***2 incidents*** |
| 5 | | Ill Health (patient) ***1 incident*** | Inappropriate behaviour (towards staff) ***4 incidents*** | Child Protection Concerns ***1 incident*** |
| 6 | | Equipment (patient) ***1 incident*** | Smoking Related Incidents ***4 incidents*** | |
| 7 | | Inappropriate behaviour (towards staff) ***1 incident*** | Concealment of items ***2 incidents*** | |
| 8 | | | Equipment (patient) ***2 incidents*** | |
| 9 | | | Injury ***1 incident*** | |
| 10 | | | Struck an object ***1 incident*** | |

There were a total of 35 incidents that occurred in May 2015 where Prone was used. This can be broken down per service area as follows:

| | Incidents | Prone Used | Trend on previous month |
|---|---|---|---|
| Adult Mental Health Services | 62 | 16 | 50 ↑ |
| LD Services | 15 | 1 | 46 ↓ |
| Forensic LD | 18 | 2 | 25 ↓ |
| Forensic MH | 20 | 4 | 66 ↓ |
| CYPS T4 | 126 | 12 | 168↓ |
| | **241** | **35** | |

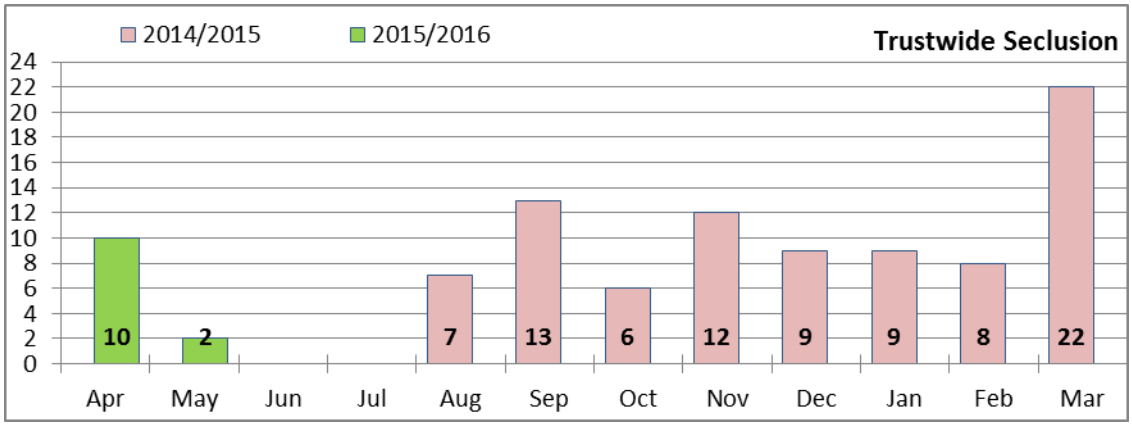
The Trust's Force Reduction project continue to focus on high users of Prone restraint although this relates to a small number of wards and individual patients within those wards and the various factors which may be contributing to this form part of the project remit.

The type of control or restraint used over the last 3 months can be found within the appendices of this report.

## 3.7 Seclusions

There have been 2 episodes of seclusion during the reporting period, this is a reduction of 8 on the previous month.

The graph below shows the number of episodes of seclusion that has occurred over the last 12 months:




*Please note: seclusion data is unavailable before August 2014.*

During the month of May 2015 the Forensic services (Ivy Ward) and North Yorkshire CAMHS (Newberry) were both users of Seclusion with 1 incident occurring in each service. It is important to highlight that the episode of seclusion on Ivy equated to 328 hours and 15 minutes. At the time of producing this report it was not clear whether a detailed report on this episode of seclusion had been produced.

For full details of Seclusions in the Reporting Calendar month please refer to the appendices.

**Tees, Esk and Wear Valleys NHS Foundation Trust**
**Quality Assurance Committee (QuAC) -**
**Patient Safety and Patient Experience Data Report**
**SECTION 4 – NEXT STEPS**

## 4.0 Next Steps

We are committed to evolving our approach in this area and are taking a number of steps to improve such as:

- Receiving feedback in relation to the format of the report and tolerances relating to the RAG rated status by the end of June 2015.

- Aligning a Quality Data Manager to each locality; this will allow closer working with our clinical services which will aid more detailed narratives being provided in future reports

- Working closely with our corporate colleagues looking at ways of capturing data and responding to feedback.

**Tees, Esk and Wear Valleys NHS Foundation Trust**
**Quality Assurance Committee (QuAC) -**
**Patient Safety and Patient Experience Data Report**
**SECTION 5 – RECOMMENDATION**

## 5.0 Recommendation

The Quality Assurance Committee are asked to:

- Receive assurance on the overall achievement on quality and performance indicators
- Feedback on the narrative style report including any areas of development would be appreciated to ensure that the report meets the needs of the QuAC group.
- RAG rating status needs to be defined in terms of the targets to be used for future reports. This would aid the identification of specific issues to the Trust and enable more focussed exception reporting.
- Agreement as to whether the locality graphs are required in future reports.
- Discussion is required in terms of how issues or risks will be identified from this report and incorporated onto the Trusts risk register.

**Joanne Salvin**
**Quality Data Manager**
**June 2015**

**Emma Haimes**
**Head of Quality Data**
**June 2015**

## 6.1 Level-4 Incidents (Reporting Calendar Month)

| Locality | Service | Ward / Team | Incident Category |
|---|---|---|---|
| Durham and Darlington | MHSOP | MHSOP Picktree Ward | Assault on patient |
| Durham and Darlington | AMH | AMH West Park Hospital Spruce | Self-harm |
| Forensic | LD | FLD Ivy Ward | Assault on staff |
| Forensic | MH | FMH Kirkdale Ward | Inappropriate Behaviour |
| North Yorkshire | MHSOP | MHSOP Scarborough Cross Lane Rowan Lea | Self-harm |
| North Yorkshire | AMH | AMH Hambleton and Richmondshire East Community | Unexpected Death (Outpatient) |
| North Yorkshire | AMH | AMH Hambleton and Richmondshire East Community | Self-harm |
| North Yorkshire | CAMHS Tier 3 | CAMHS Harrogate | Self-harm |
| Teesside | MHSOP | MHSOP North Tees Liaison Psychiatry | Self-harm |
| Teesside | AMH | AMH Bilsdale Ward | Self-harm |

### 6.2 Level-3 (Self-Harm) Incidents (Reporting Calendar Month)

| Locality | Service | Ward / Team | Incident Sub Category |
|---|---|---|---|
| Durham & Darlington | CYPS | CAMHS D&D Eating Disorders | Actual self harm |
| Durham & Darlington | CYPS | CAMHS D&D Crisis | Actual self harm |
| Durham & Darlington | CYPS | CAMHS D&D Crisis | Actual self harm |
| Durham & Darlington | AMH | AMH Easington Affective Dis | Attempted or suspected attempted suicide |
| Durham & Darlington | CYPS | CAMHS D&D Crisis | Actual self harm |
| Durham & Darlington | AMH | AMH WPH Maple Ward | Actual self harm |
| Durham & Darlington | CYPS | CAMHS D&D Crisis | Actual self harm |
| Durham & Darlington | CYPS | CAMHS D&D Crisis | Actual self harm |
| Durham & Darlington | CYPS | CAMHS D&D Crisis | Actual self harm |
| Durham & Darlington | CYPS | CAMHS D&D Crisis | Actual self harm |
| Durham & Darlington | CYPS | CAMHS D&D Crisis | Actual self harm |
| Durham & Darlington | CYPS | CAMHS South Durham Tier 3 | Actual self harm |
| Durham & Darlington | CYPS | CAMHS D&D Crisis | Actual self harm |
| Durham & Darlington | AMH | AMH D&D IAPT 2/3rds | Attempted or suspected attempted suicide |
| Durham & Darlington | MHSOP | MHSOP Darlington & Teesdale Comm | Actual self harm |
| Durham & Darlington | CYPS | CAMHS D&D Crisis | Actual self harm |
| Durham & Darlington | CYPS | CAMHS D&D Crisis | Actual self harm |
| Durham & Darlington | AMH | AMH IP D&D Primrose Lodge | Actual self harm |

| | | | |
|---|---|---|---|
| Durham & Darlington | CYPS | CAMHS D&D Crisis | Actual self harm |
| Durham & Darlington | AMH | AMH WPH Elm Ward | Actual self harm |
| Forensic | MH | FMH RP Fulmar (Female) Ward | Actual self harm |
| Forensic | LD | FLD RP Ivy Ward | Actual self harm |
| Forensic | MH | FMH RP Brambling Ward | Actual self harm |
| North Yorkshire | CYPS | CAMHS Northallerton | Actual self harm |
| North Yorkshire | CYPS | CAMHS IP WLH Westwood Centre | Actual self harm |
| North Yorkshire | MHSOP | MHSOP IP Scarborough Rowan Lea | Actual self harm |
| North Yorkshire | CYPS | CAMHS Harrogate | Actual self harm |
| North Yorkshire | MHSOP | MHSOP IP Harrogate Rowan | Actual self harm |
| North Yorkshire | CYPS | CAMHS Harrogate | Actual self harm |
| North Yorkshire | CYPS | CAMHS Scarborough | Actual self harm |
| North Yorkshire | AMH | AMH Ham&Rich East Community | Actual self harm |
| North Yorkshire | AMH | AMH HHR Early Intervention Psy | Drug abuse |
| North Yorkshire | CYPS | CAMHS Harrogate | Attempted or suspected attempted suicide |
| Teesside | MHSOP | MHSOP N Tees Liaisn Psychiatry | Actual self harm |
| Teesside | AMH | AMH RP Bransdale Ward | Actual self harm |
| Teesside | AMH | AMH RP Bilsdale Ward | Actual self harm |
| Teesside | CYPS | CAMHS Stockton Community | Attempted self harm |

| | | | |
|---|---|---|---|
| Teesside | CYPS | CAMHS Stockton Community | Actual self harm |
| Teesside | CYPS | CAMHS Stockton Community | Attempted or suspected attempted suicide |
| Teesside | CYPS | CAMHS Extended Liaison Service | Actual self harm |
| Teesside | AMH | AMH RP Bransdale Ward | Actual self harm |
| Teesside | CYPS | CAMHS Mboro Community | Actual self harm |
| Teesside | AMH | AMH RP Bilsdale Ward | Actual self harm |
| Teesside | LD | ALD Bankfields Court 3 | Actual self harm |

### 6.3 Complaints (Reporting Calendar Month)

| Locality | Ward/Team | DATIX ID | First received | Subject (primary) | Sub-subject (primary) | Description | Outcome |
|---|---|---|---|---|---|---|---|
| Forensic LD | FLD RP Hawthorne Ward | 1240 | 12-May-2015 | Environment | Catering | Patient raised concern about staff receiving meals from the server on the ward and concerns regarding the football playing area | Ongoing |
| Durham & Darlington | AMH Darlington Affective Dis | 1241 | 15-May-2015 | Clinical Care | Treatment and Care | Concerns regarding lack of support from the team and lack of contact from the care coordinator. | Ongoing |
| Teesside | MHSOP RP Westerdale North | 1242 | 19-May-2015 | Clinical Care | Transfer | Concerns raised about relatives care and treatment following transfer to another hospital within the Trust. | Ongoing |
| Durham & Darlington | AMH WPH Maple Ward | 1248 | 19-May-2015 | Communication | Confidentiality | Alleged breach of confidentiality by a staff member. | Ongoing |
| Teesside | MHSOP RP Westerdale North | 1247 | 21-May-2015 | Environment | Noise | Patient raised concerns in relation to noise level on ward, a female patient using the male patients quiet room and the courtyard area being neglected. | Ongoing |
| Teesside | AMH R&C Crisis Resolution | 1243 | 22-May-2015 | Clinical Care | Medication | Patient unhappy with diagnosis and felling unwell due to withdrawal of medication. | Ongoing |
| North Yorkshire | AMH Harrogate Community | 1244 | 26-May-2015 | Clinical Care | Medication | Dissatisfied with response of CMHT | Ongoing |
| Teesside | AMH Hartlepool Affective Dis | 1246 | 26-May-2015 | Attitude | Rudeness | Concerns raised about staff's rude attitude at an appointment and poor standard of overall care. | Ongoing |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Teesside | AMH RP PICU | 1245 | 27-May-2015 | Clinical Care | Therapeutic Intervention | Relative raised concerns regarding length of stay on ward, lack of therapeutic intervention and lack of support received as a carer. | Ongoing |

## 6.4 Control and Restraint

The type of control or restraint used (may be more than one per incident) over the last 3 months (March to May) is as follows:

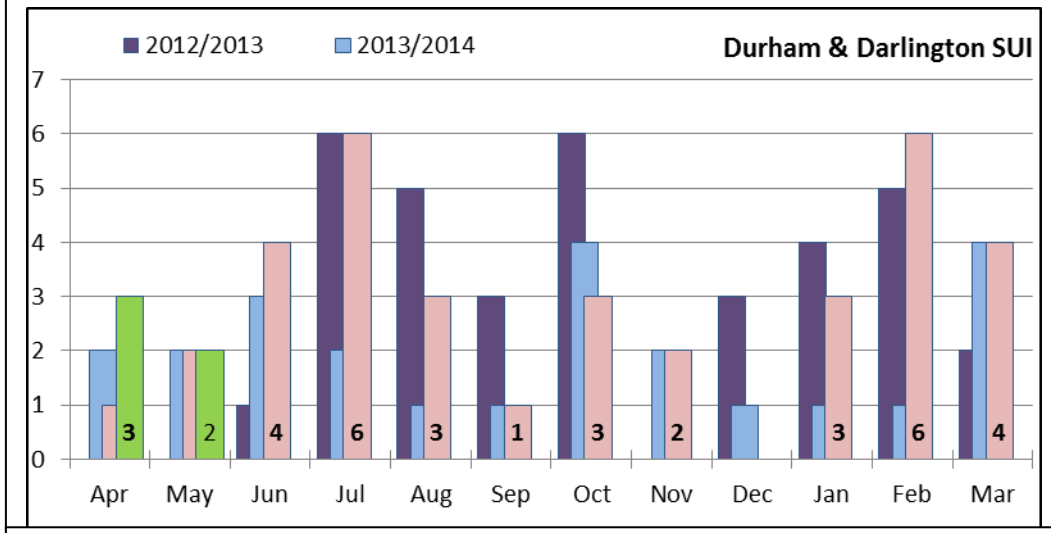
| Trustwide (3-Months Mar-May) | Number of Incidents | Type of Control or Restraint Used (May be more than one per incident) | | | | | | | | | | | | | | | | | | Total Controls or Restraints used |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Locality/Speciality Area | | PRO | AFF | AFT | AWH | BBW | BCG | BDK | BHP | BST | BWG | ERC | ERB | SBB | SCH | SEC | SUP | TES | TNL | |
| Durham & Darlington AMH | 56 | 15 | 11 | | | | 5 | 5 | 26 | 4 | 19 | 3 | | 1 | | | | | 8 | **97** |
| Durham & Darlington CAMHS | 1 | | | | | | | | | | | | | 1 | | 1 | | | | **2** |
| Durham & Darlington LD | 38 | 3 | 4 | | | | | 1 | 30 | | | 8 | 5 | 3 | 1 | 3 | 1 | | 1 | **60** |
| Durham & Darlington MHSOP | 87 | | 3 | | | | | 1 | 73 | | 10 | 16 | | 1 | | | | | 4 | **108** |
| Forensic LD | 103 | 10 | 16 | 6 | 1 | | 13 | 22 | 67 | 6 | 28 | 8 | 1 | 2 | | | | 1 | 1 | **182** |
| Forensic MH | 226 | 31 | 83 | 11 | 4 | | | 30 | 85 | 18 | 104 | | | 2 | | | | | 3 | **371** |
| North Yorkshire AMH | 42 | 14 | 4 | | | | | 7 | 18 | 4 | 20 | 3 | 1 | 3 | | | 1 | | 3 | **78** |
| North Yorkshire MHSOP | 68 | | 1 | | | | | 9 | 43 | 3 | 22 | 3 | 1 | 2 | | | | | 6 | **90** |
| North Yorkshire CAMHS T4 | 431 | 42 | 116 | 1 | | 1 | 197 | 33 | 260 | 27 | 129 | 3 | | 2 | | 1 | | | 21 | **833** |
| Teesside AMH | 63 | 5 | 8 | 1 | | | | 11 | 41 | 1 | 15 | 2 | 1 | 1 | 2 | | 1 | | 5 | **94** |
| Teesside CAMHS | 1 | | | | | | | | | | | | | | | | | | 1 | **1** |
| Teesside LD | 93 | | 11 | | | | 26 | 3 | 70 | 2 | 1 | 3 | 3 | 2 | | 1 | 1 | | 6 | **129** |
| Teesside MHSOP | 8 | | | | | | | 1 | 7 | 1 | 1 | 1 | | | | | | | | **11** |
| **Grand Total** | **1217** | **120** | **257** | **19** | **5** | **1** | **241** | **123** | **720** | **66** | **349** | **50** | **12** | **20** | **3** | **6** | **4** | **1** | **59** | **2056** |

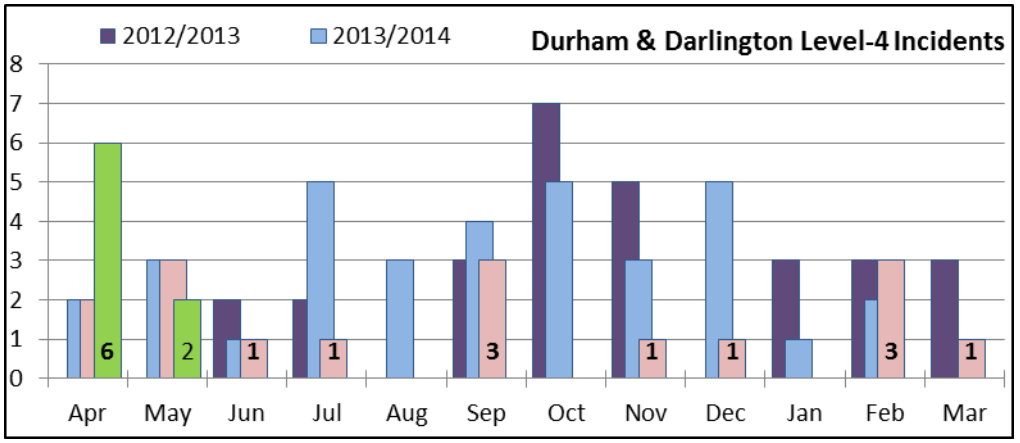
## 6.5 Seclusions (Reporting Calendar Month)

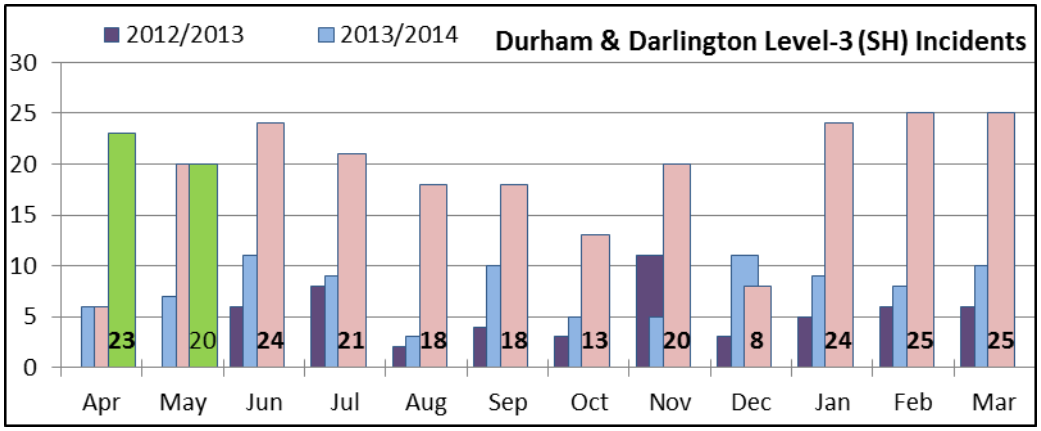
| Locality | Service | Ward / Team | MHA Section | Date Commenced | Time | Date Concluded | Time | Time in Seclusion (hours:minutes) | Report Received over 24hr |
|---|---|---|---|---|---|---|---|---|---|
| Forensic | LD | Ivy Ward | 3 | 05/05/2015 | 18.45 | 19/05/2015 | 10.00 | 328h 15m | |
| North Yorkshire | CAMHS Tier 4 | Newberry Ward | 2 | 30/05/2015 | 19.00 | 30/05/2015 | 21.00 | 2hr | N/A |

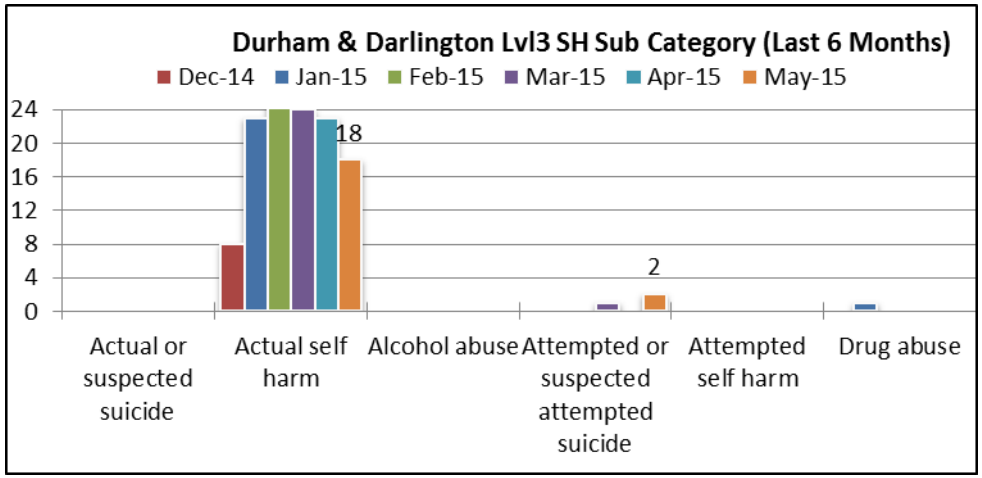
# Tees, Esk and Wear Valleys NHS Foundation Trust
# Quality Assurance Committee (QuAC) -
# Patient Safety and Patient Experience Data Report
# SECTION 7 – APPENDICES BY LOCALITY

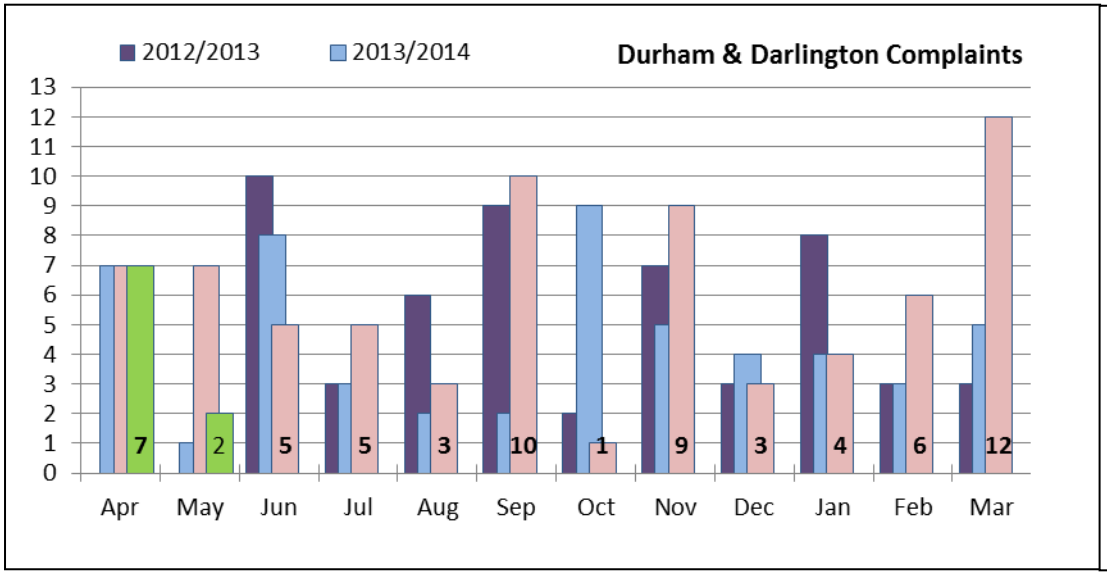
## Durham & Darlington




2012/2013
2013/2014
Durham & Darlington Complaints
13
12
11
10
9
8
7
6
5
4
3
2
1
0
7
2
5
5
3
10
1
9
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Apr
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Jun
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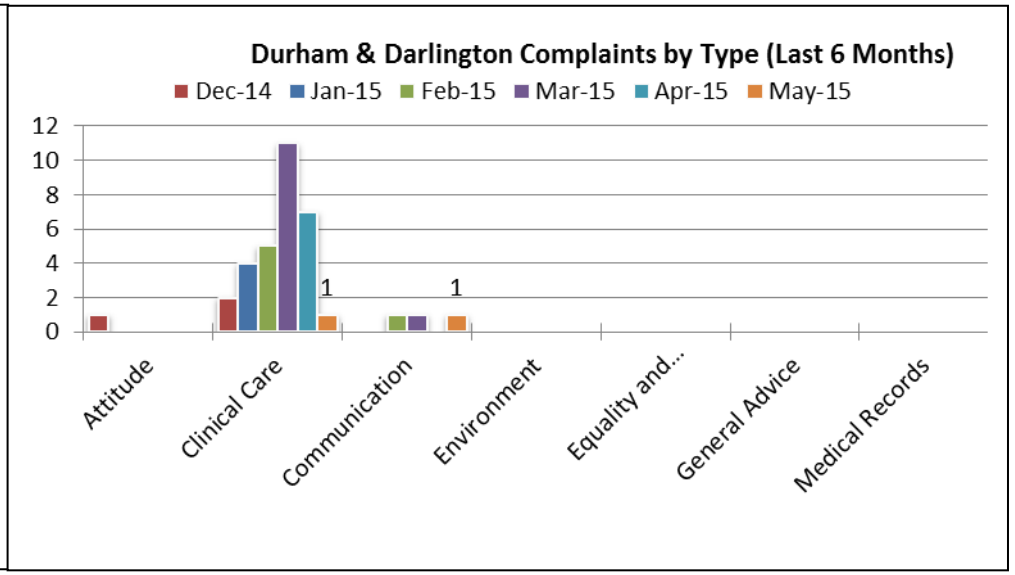
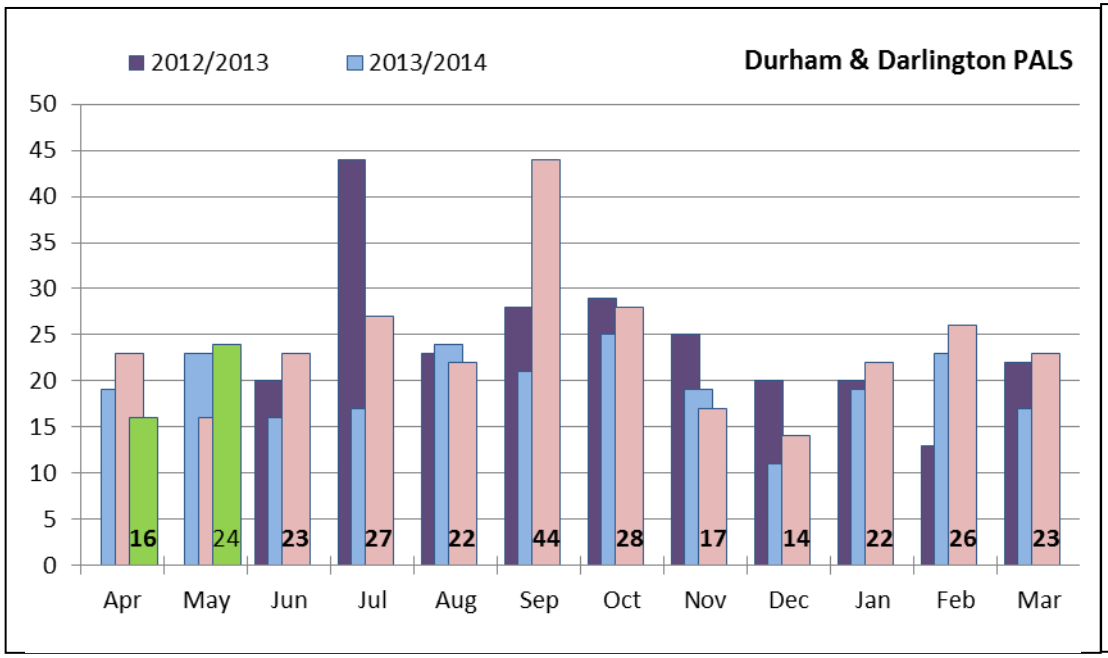
Oct
Nov
Dec
Jan
Feb
Mar


Durham & Darlington Complaints by Type (Last 6 Months)
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
12
10
8
6
4
2
0
1
1
Attitude
Clinical Care
Communication
Environment
Equality and...
General Advice
Medical Records


2012/2013
2013/2014
Durham & Darlington PALS
50
45
40
35
30
25
20
15
10
5
0
16
24
23
27
22
44
28
17
14
22
26
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Apr
May
Jun
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Aug
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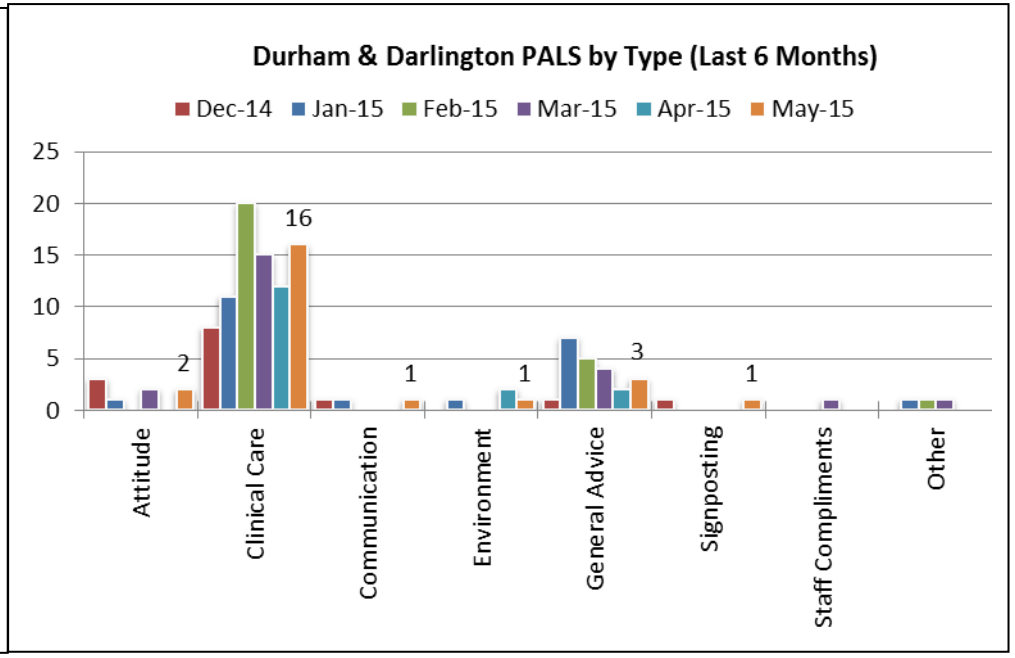
Oct
Nov
Dec
Jan
Feb
Mar


Durham & Darlington PALS by Type (Last 6 Months)
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
25
20
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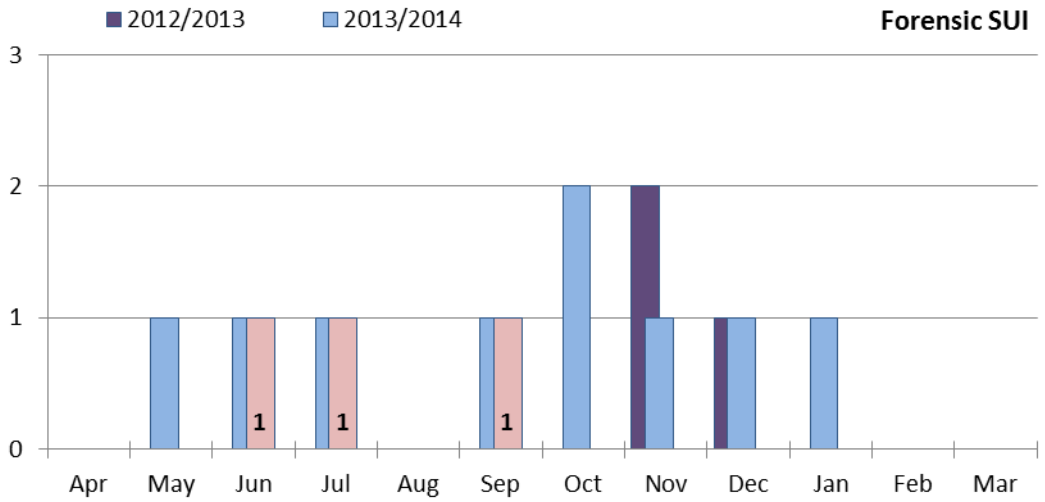
Attitude
Clinical Care
Communication
Environment
General Advice
Signposting
Staff Compliments
Other

## Forensic


2012/2013
2013/2014
Forensic SUI
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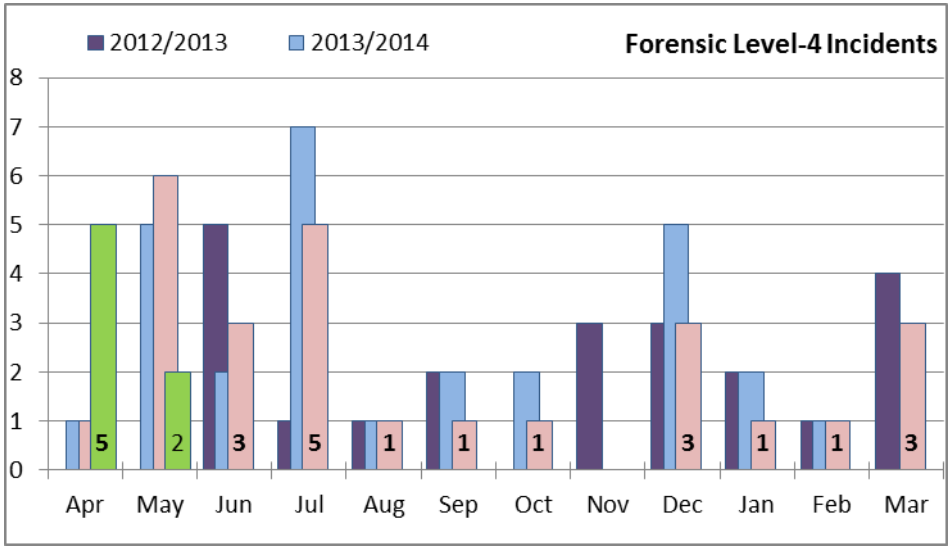
2012/2013
2013/2014
Forensic Level-4 Incidents
8
7
6
5
4
3
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5
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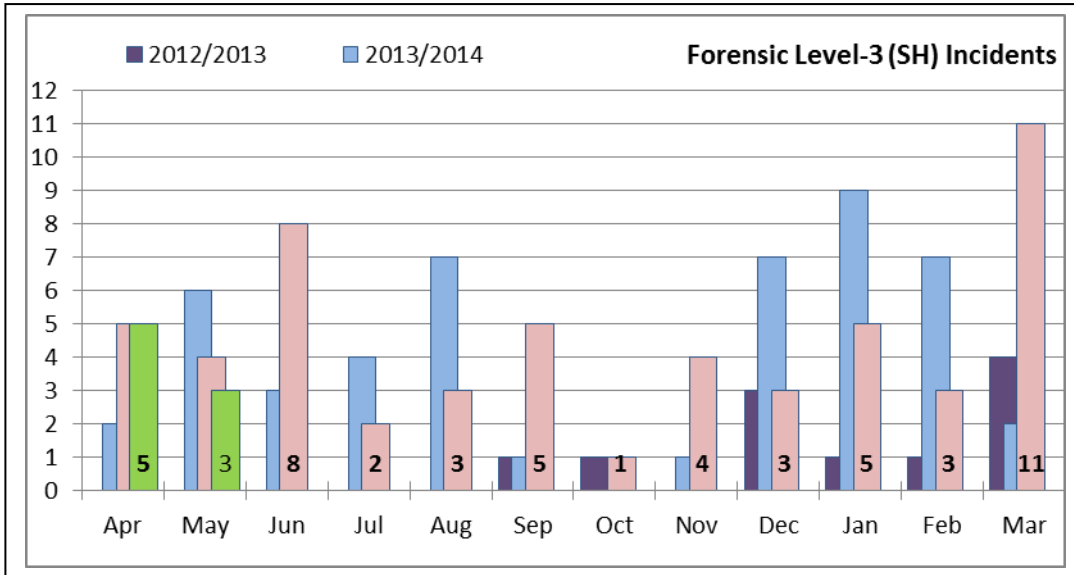
1
3


2012/2013
2013/2014
Forensic Level-3 (SH) Incidents
12
11
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9
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4
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Jun
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Oct
Nov
Dec
Jan
Feb
Mar
5
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8
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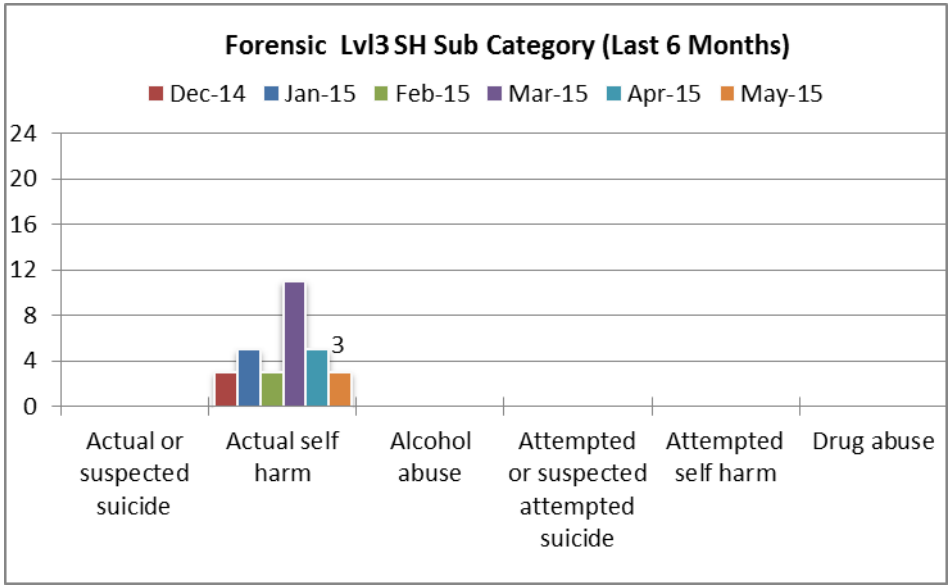
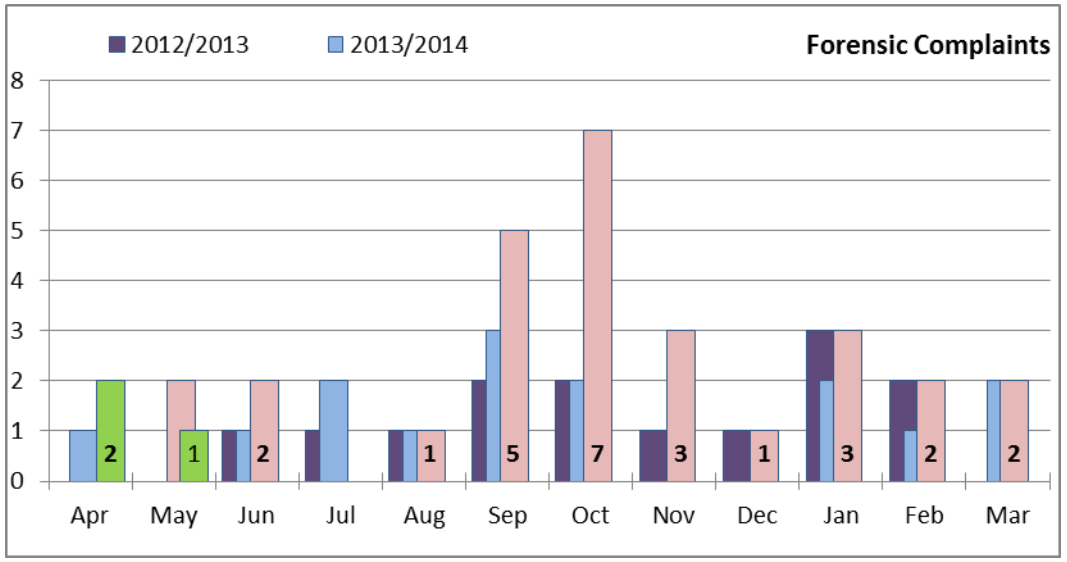
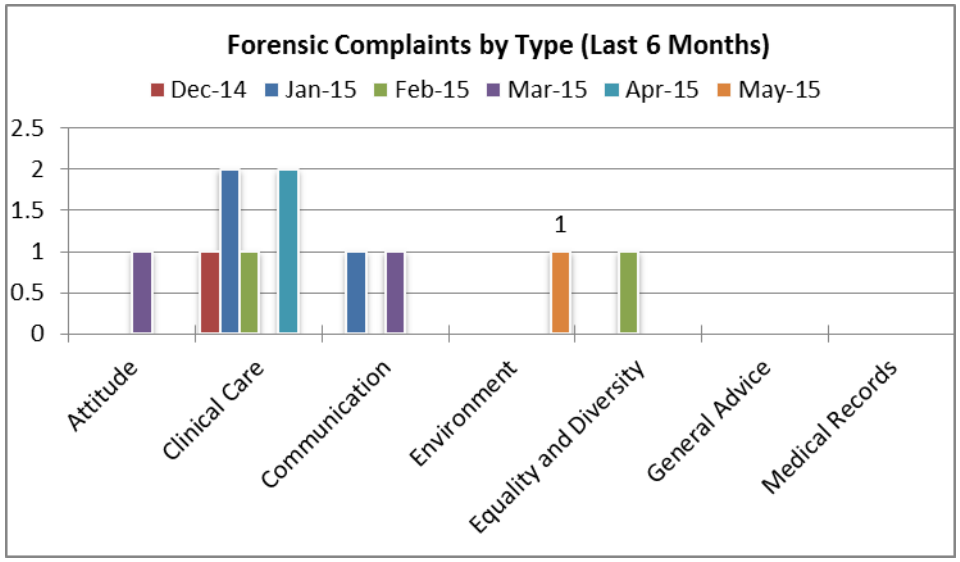
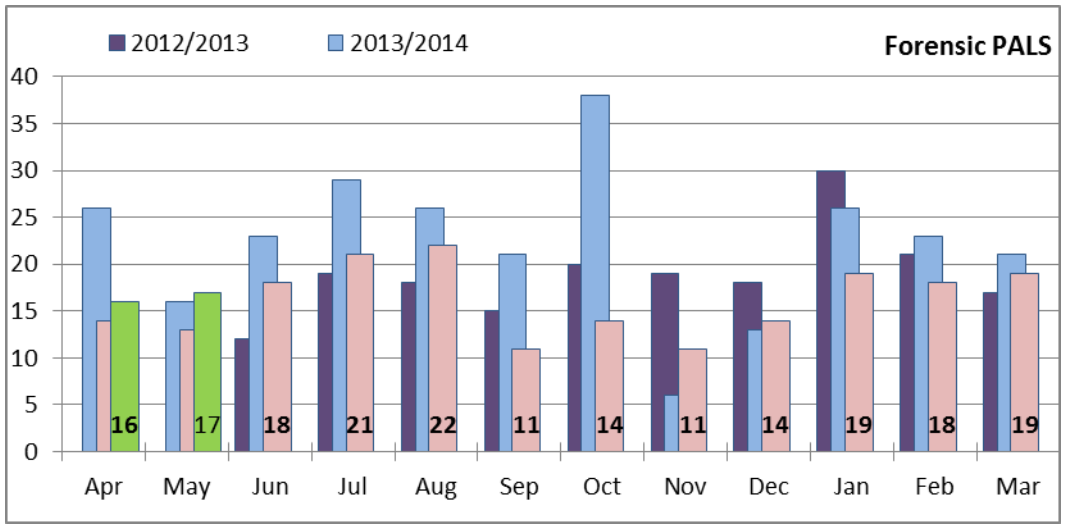
3
5
1
4
3
5
3
11


Forensic Lvl3 SH Sub Category (Last 6 Months)
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
24
20
16
12
8
4
0
3
Actual or suspected suicide
Actual self harm
Alcohol abuse
Attempted or suspected attempted suicide
Attempted self harm
Drug abuse


2012/2013
2013/2014
Forensic Complaints
8
7
6
5
4
3
2
1
0
2
1
2
1
5
7
3
1
3
2
2
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Forensic Complaints by Type (Last 6 Months)
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
2.5
2
1.5
1
0.5
0
1
Attitude
Clinical Care
Communication
Environment
Equality and Diversity
General Advice
Medical Records


2012/2013
2013/2014
Forensic PALS
40
35
30
25
20
15
10
5
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16
17
18
21
22
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Apr
May
Jun
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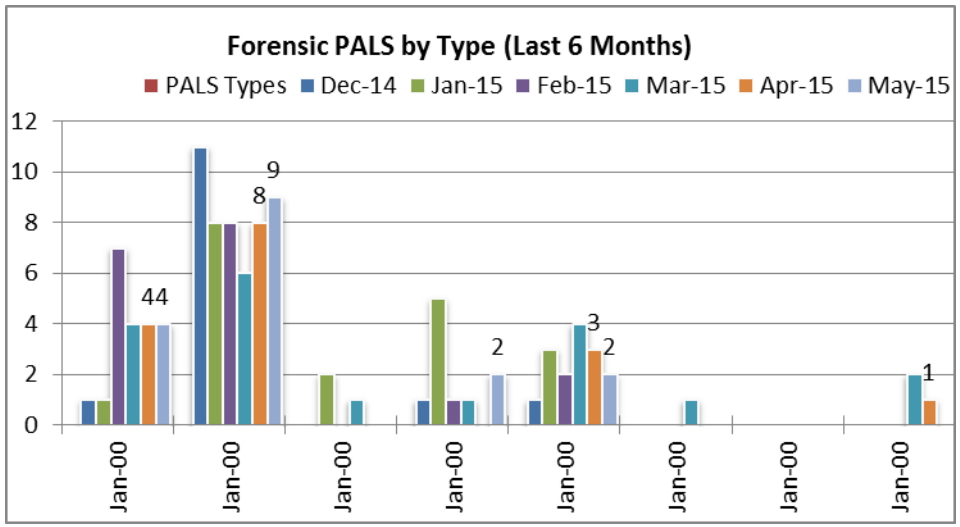
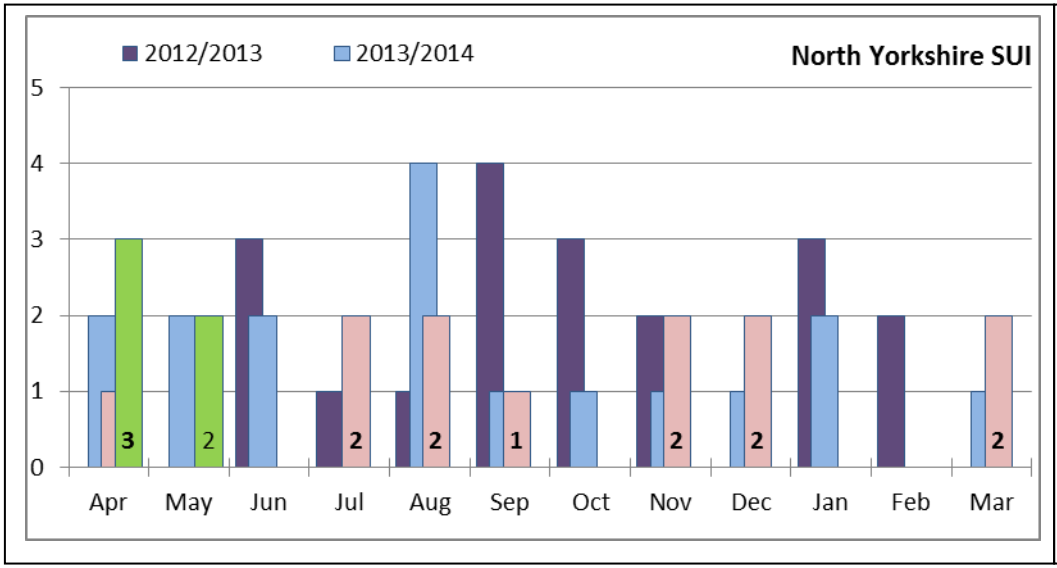
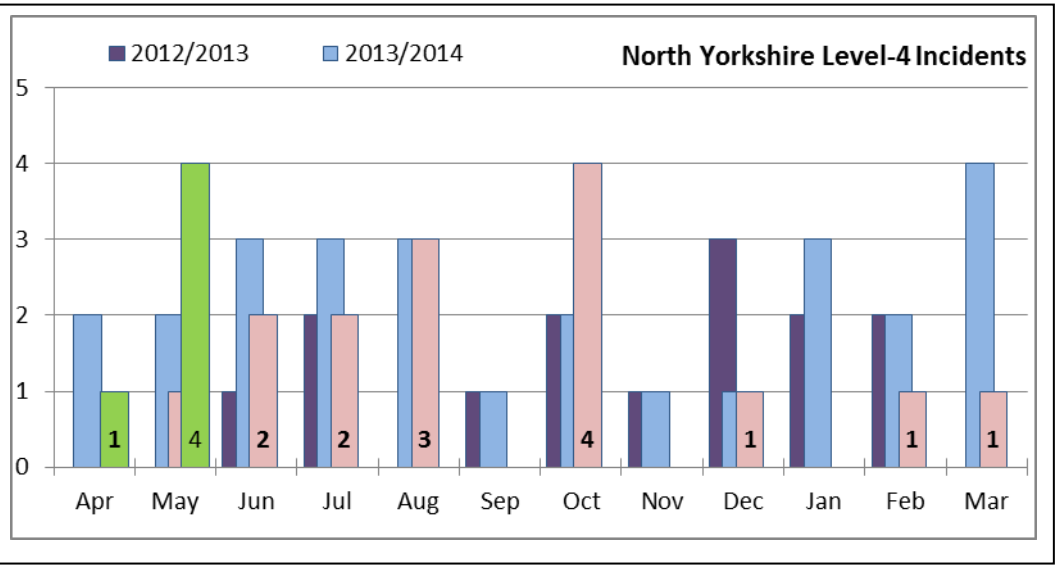
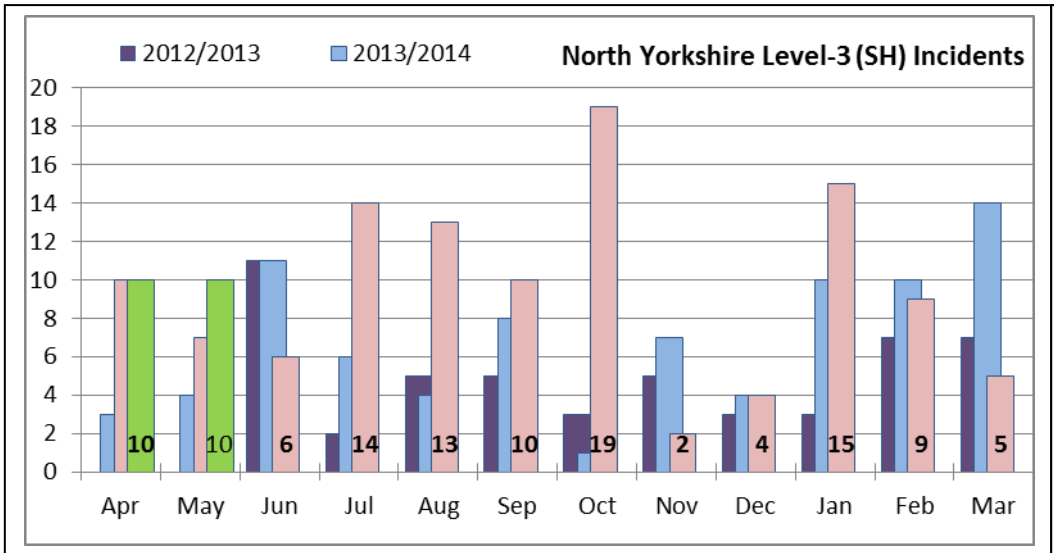
Nov
Dec
Jan
Feb
Mar

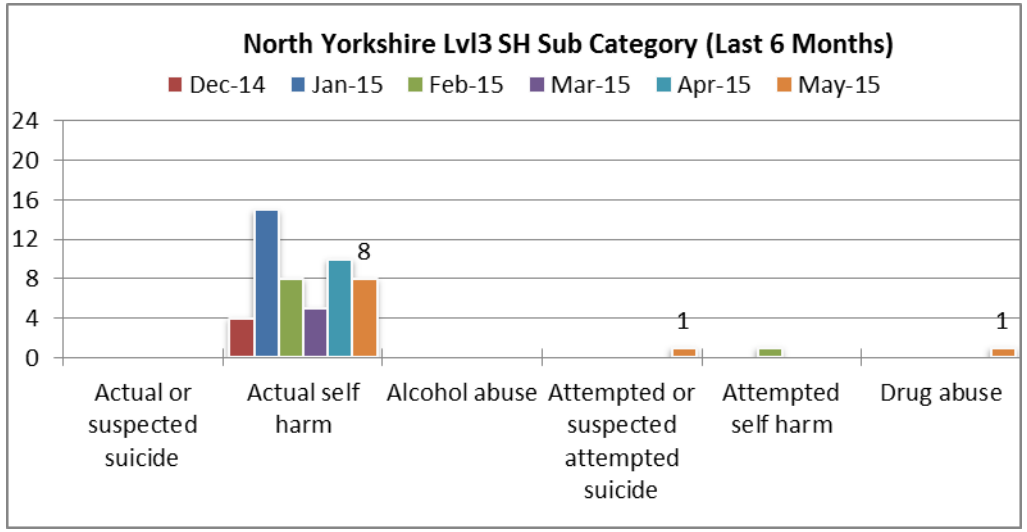

Forensic PALS by Type (Last 6 Months)
PALS Types
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
12
10
8
6
4
2
0
44
9
8
2
3
2
1
Jan-00
Jan-00
Jan-00
Jan-00
Jan-00
Jan-00
Jan-00
Jan-00

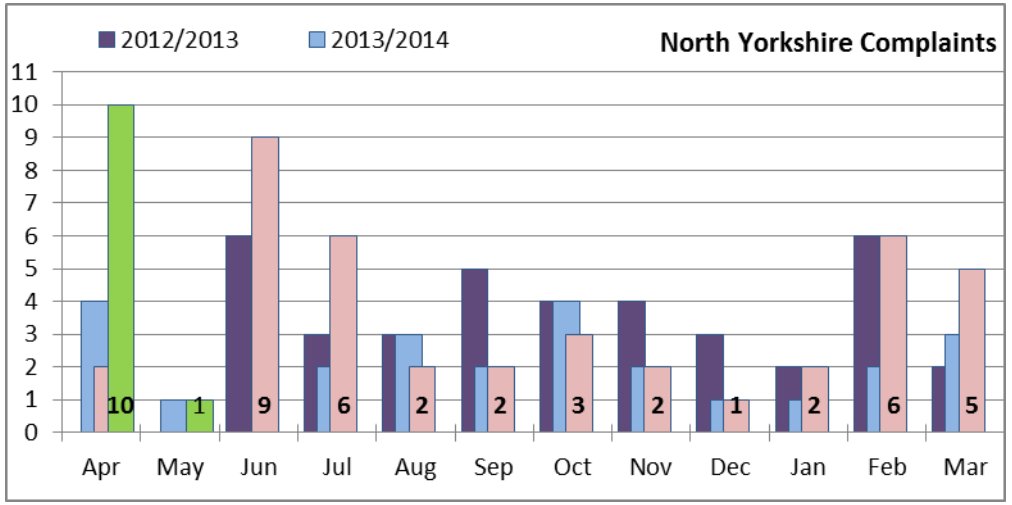
## North Yorkshire




2012/2013
2013/2014
North Yorkshire Complaints
11
10
9
8
7
6
5
4
3
2
1
0
10
1
9
6
2
2
3
2
1
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Apr
May
Jun
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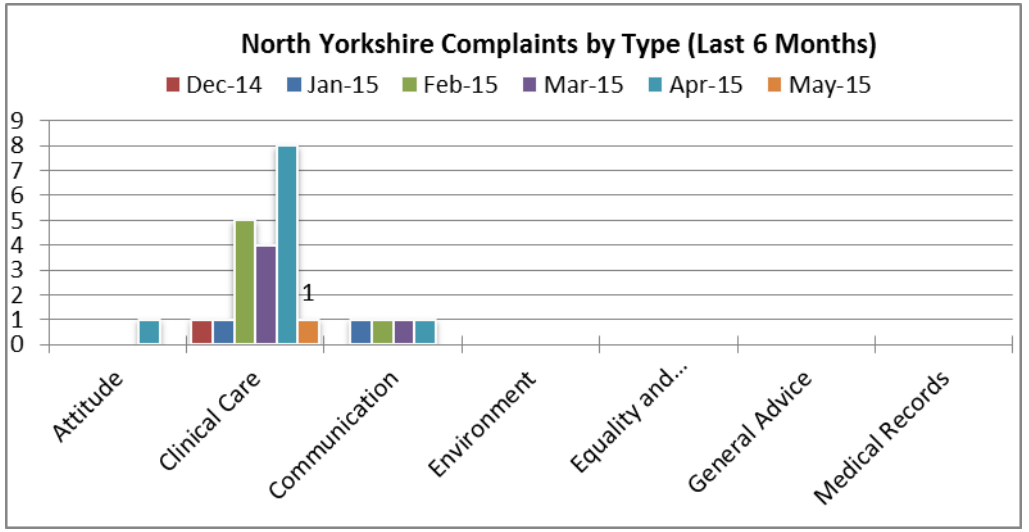
Sep
Oct
Nov
Dec
Jan
Feb
Mar


North Yorkshire Complaints by Type (Last 6 Months)
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
9
8
7
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5
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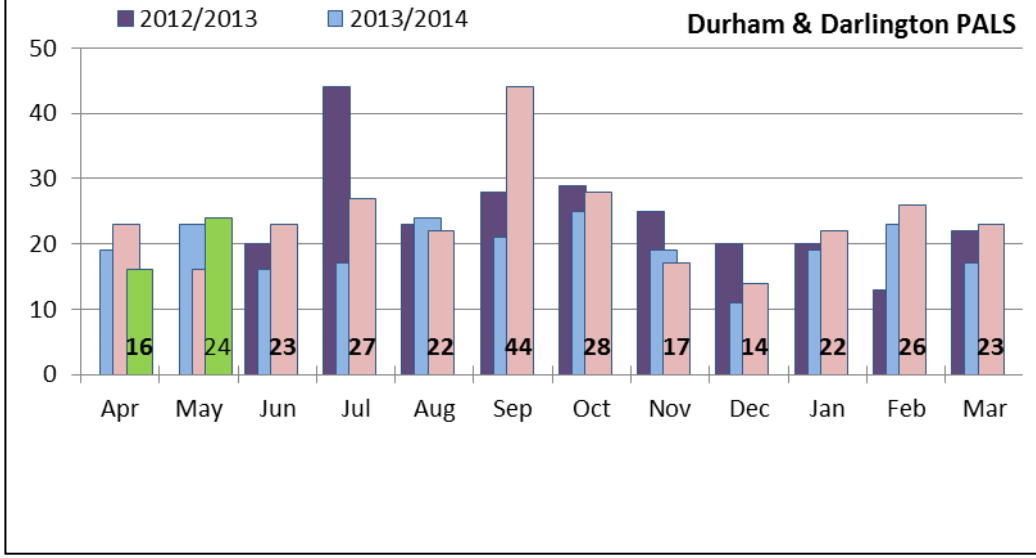
1
Attitude
Clinical Care
Communication
Environment
Equality and...
General Advice
Medical Records


2012/2013
2013/2014
Durham & Darlington PALS
50
40
30
20
10
0
16
24
23
27
22
44
28
17
14
22
26
23
Apr
May
Jun
Jul
Aug
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Jan
Feb
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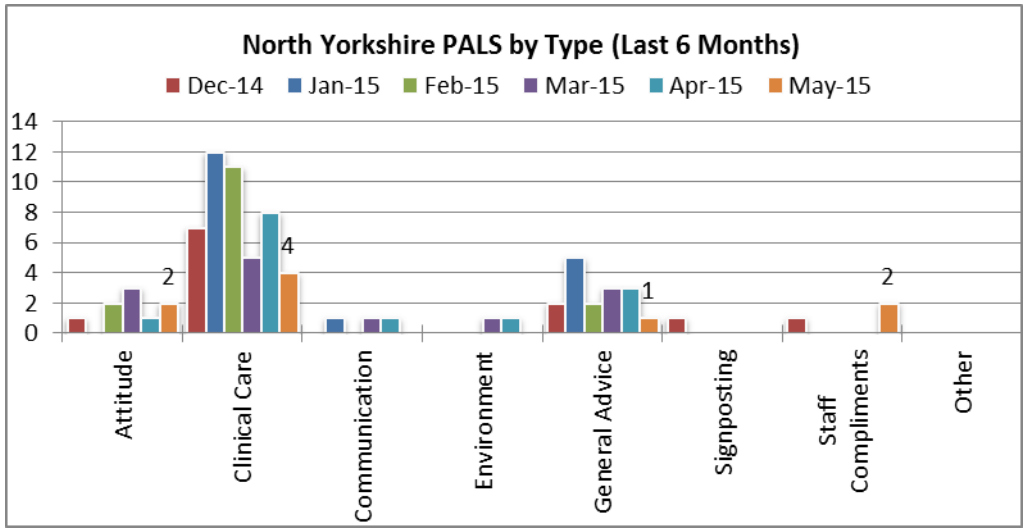
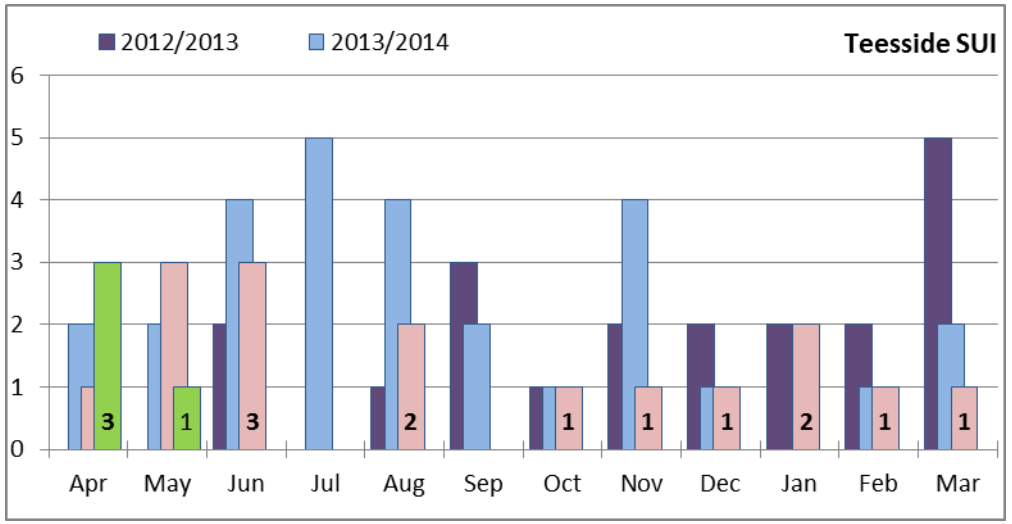

North Yorkshire PALS by Type (Last 6 Months)
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
14
12
10
8
6
4
2
0
2
4
1
2
Attitude
Clinical Care
Communication
Environment
General Advice
Signposting
Staff Compliments
Other

## Teesside


2012/2013
2013/2014
Teesside SUI
6
5
4
3
2
1
0
3
1
3
2
1
1
1
2
1
1
Apr
May
Jun
Jul
Aug
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Oct
Nov
Dec
Jan
Feb
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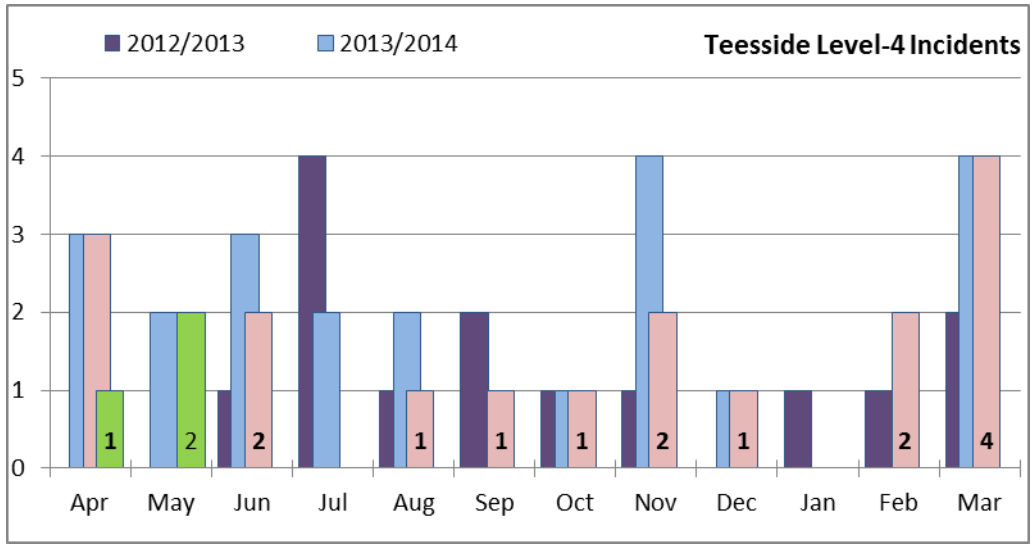
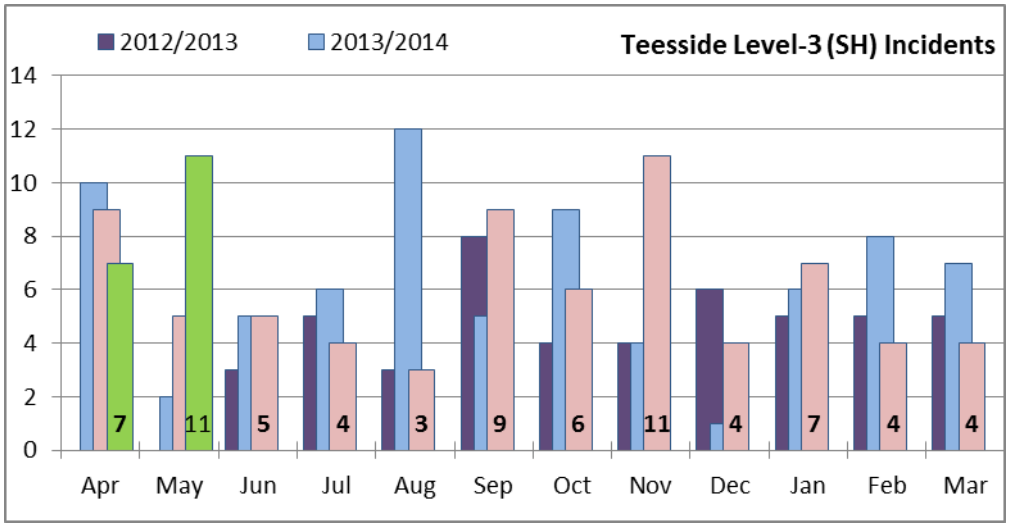

2012/2013
2013/2014
Teesside Level-4 Incidents
5
4
3
2
1
0
1
2
2
1
1
1
2
1
2
4
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


2012/2013
2013/2014
Teesside Level-3 (SH) Incidents
14
12
10
8
6
4
2
0
7
11
5
4
3
9
6
11
4
7
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Apr
May
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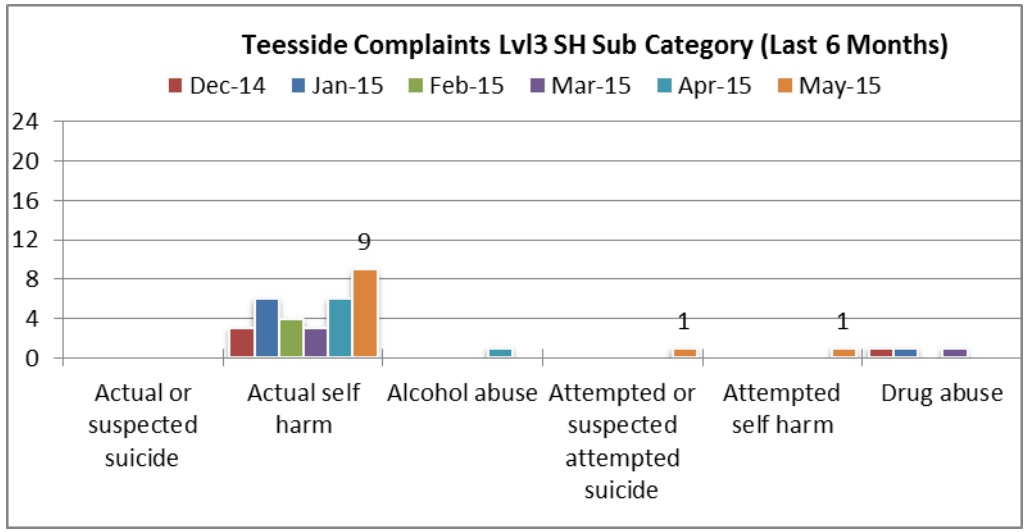
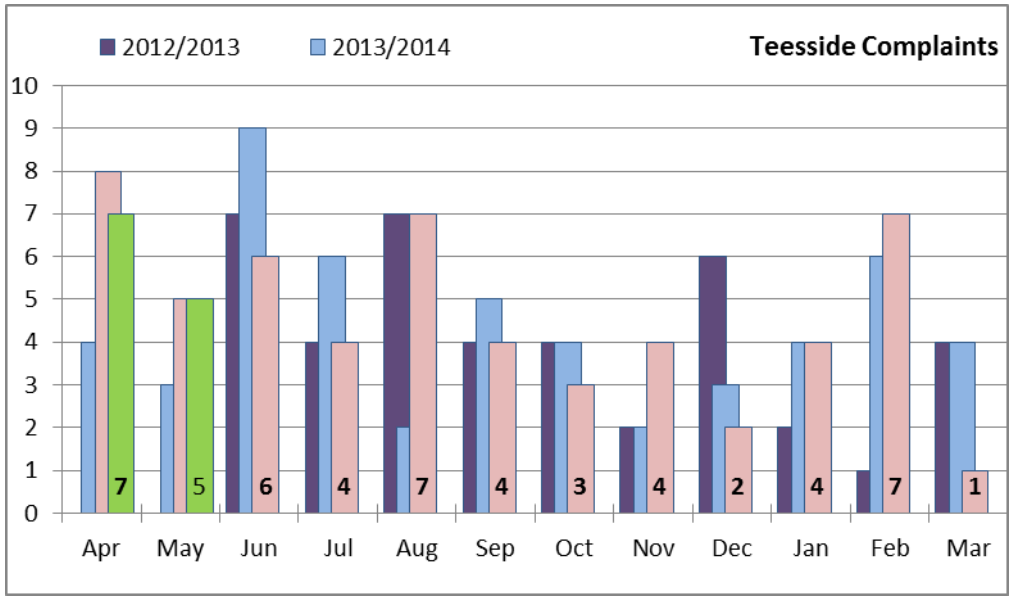
Feb
Mar


Teesside Complaints Lvl3 SH Sub Category (Last 6 Months)
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
24
20
16
12
8
4
0
9
1
1
Actual or suspected suicide
Actual self harm
Alcohol abuse
Attempted or suspected attempted suicide
Attempted self harm
Drug abuse


2012/2013
2013/2014
Teesside Complaints
10
9
8
7
6
5
4
3
2
1
0
7
5
6
4
7
4
3
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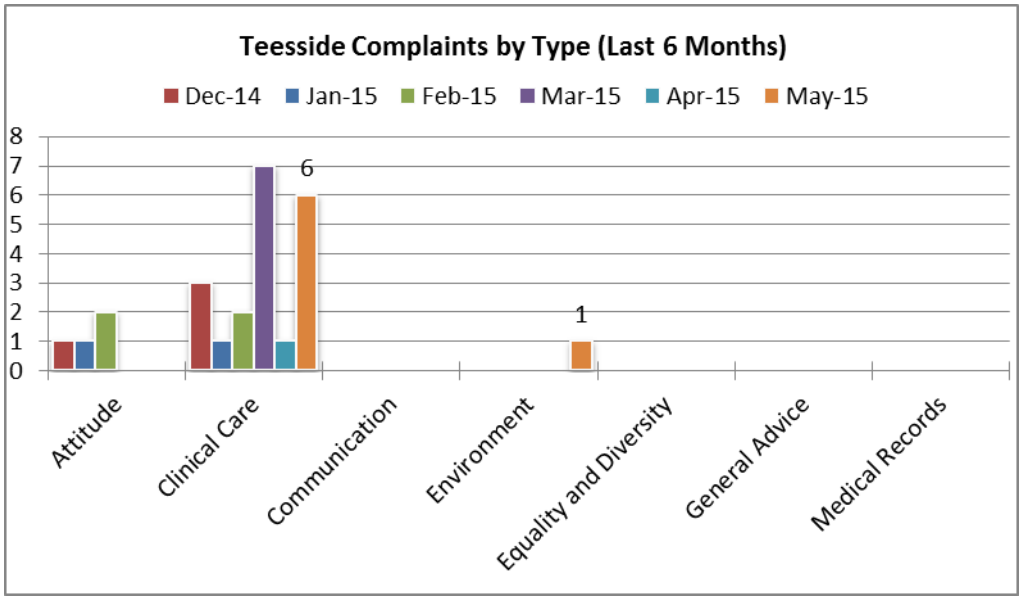
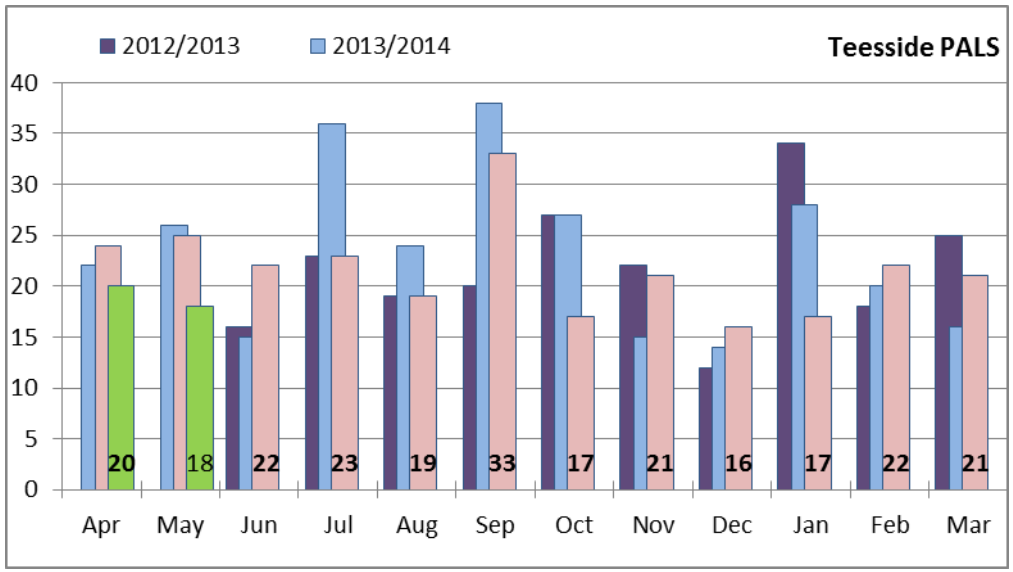
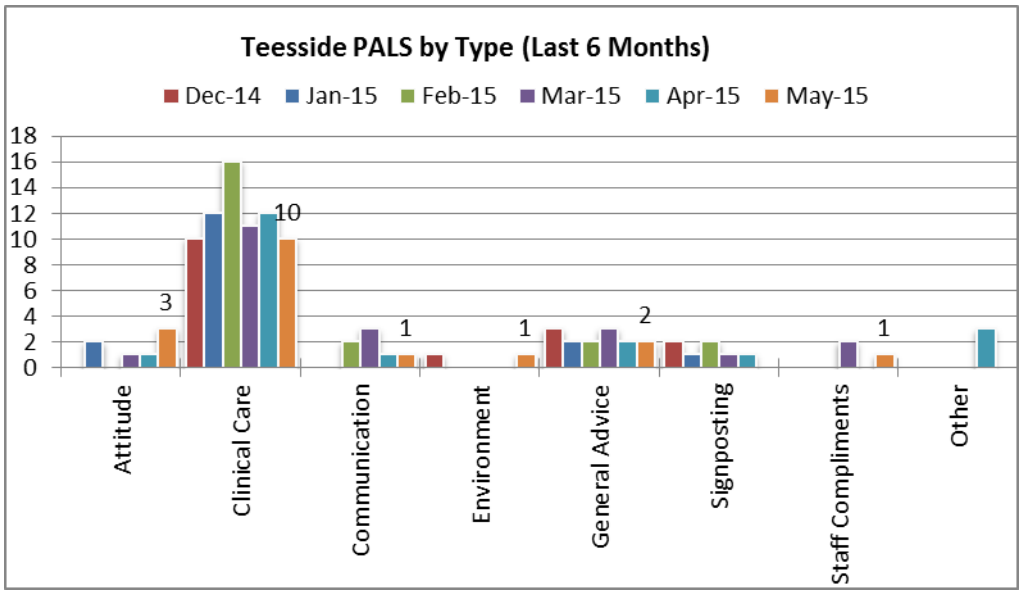
2
4
7
1
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Teesside Complaints by Type (Last 6 Months)
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
8
7
6
5
4
3
2
1
0
6
1
Attitude
Clinical Care
Communication
Environment
Equality and Diversity
General Advice
Medical Records


2012/2013
2013/2014
Teesside PALS
40
35
30
25
20
15
10
5
0
20
18
22
23
19
33
17
21
16
17
22
21
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Teesside PALS by Type (Last 6 Months)
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
18
16
14
12
10
8
6
4
2
0
3
10
1
1
2
1
Attitude
Clinical Care
Communication
Environment
General Advice
Signposting
Staff Compliments
Other

**Item 8**

# BOARD OF DIRECTORS

**Date of Meeting:** **23rd July 2015**

**Title:** **To consider an annual report on nurse staffing**

**Lead Director:** **Chris Stanbury, Director of Nursing and Governance**

**Report for:** **Information and assurance**

## This report includes/supports the following areas:

| **STRATEGIC GOALS:** | ✓ |
|---|---|
| **To provide excellent services working with the individual users of our services and their carers to promote recovery and well being** | ✓ |
| **To continuously improve the quality and value of our work** | ✓ |
| **To recruit, develop and retain a skilled and motivated workforce** | ✓ |
| **To have effective partnerships with local, national and international organisations for the benefit of our communities** | |
| **To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities** | ✓ |

| **CQC REGISTRATION: Outcomes (✓)** | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | ✓ | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | ✓ | Cleanliness and infection control | ✓ | Management of medicines | ✓ |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | ✓ | Staffing | ✓ | Supporting workers | ✓ |
| **Quality and management** | | | | | |
| Statement of purpose | ✓ | Assessing and monitoring quality of service provision | ✓ | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | ✓ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

**BOARD OF DIRECTORS**

**Date of Meeting:** **23rd July 2015**

**Title:** **To consider an annual report on nurse staffing**

## 1. INTRODUCTION AND PURPOSE

1.1 To advise the Board of an annual review (1st June 2014 to 31st May 2015) of issues, trends and quality indicators in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review)

## 2. BACKGROUND

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

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

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

## 3 KEY ISSUES

3.1 A number of issues have arisen in discussion of the monthly nurse staffing reports that were taken into account in this annual review –namely the level of contact time of nursing staff with patients and how additional staffing is being used and deployed.

### 3.2 Staffing and Establishments

3.2.1 It was anticipated that there would be NICE guidance relating to safe staffing in Mental Health Services later this year. This work has now transferred to NHS England.

3.2.2 A mental health framework has been devised on establishing staffing levels; the framework is available now as an interactive website and includes suggested staffing calculation tools and issues for Boards to consider.

3.2.3 The budgeted staffing establishments as at 1st June 2014 and the 31st May 2015 have been obtained from HealthRoster and have been used to compare the actual establishments in post. Attached at appendix 1 is the full narrative with the detailed breakdown provided at appendix 2 of this report. The key points are as follows:

- Durham & Darlington – budgeted establishments have increased for both registered and unregistered nurses. Section 136 Place of Safety unit attracted additional staffing resource from commissioners in this period. The review highlighted that there are less staff in post across 7 of their wards.
- North Yorkshire – budgeted establishments have increased for both registered and unregistered nurses across a number of wards. Rowan Lea have less registered staff in post in May 2015 when compared to June 2014.
- Forensic Services – budgeted establishments have reduced for both registered and unregistered nurses. Forensic LD has seen a reduction in the budgeted establishments for registered nurses and an increase in unregistered nurses.
- Teesside – budgeted establishments have reduced for both registered and unregistered nurses. There have been a number of ward closures and changes to the electronic rosters. 6 wards have less unregistered staff in post in May 2015 when compared to June 2014.

3.2.4 An increase of 12.65WTE's can be observed within the Multi-Disciplinary Team which was due to new services being commissioned. Appendix 3 outlines the budgeted establishments.

## 4.0 Workforce Variances

4.1 Sickness and vacancies were cited as the biggest factors impacting on staffing availability. Appendix 4 contains the full breakdown.

4.2 Where a patients observation levels change this requires additional duties to be created which are over and above the budgeted establishments. In June 2014 an additional 1,186 additional duties were created and only 905 were created in May 2015, this is a reduction of 281 duties.

## 5.0 Occupancy Rates

5.1 The analysis would suggest that there is no correlation between occupancy rates and staffing. In addition the data does not suggest a greater use of bank as a result of high occupancy rates.

## 6.0 Mental Health Act Activity

6.1 There are varying levels of mental health act activity across the year which makes it difficult to draw any meaningful conclusions as to the impact on safe staffing levels.

## 7.0 Planned versus Actual Hours Worked

7.1 All months with the exception of December 2014 show that our actual hours worked exceeds the planned.

7.2 The 12 month average shows that there were 22 wards who had fill rates of less than 89.9% for registered nurses on daytime shifts and only 6 wards for un-registered.

7.3 The night time position averaged across the 12 month period showed that there were 6 wards who had fill rates of less than 89.9% for registered nurses and only 1 ward for unregistered nurses.

7.4 The month on month trend shows the average fill rate for registered nurses on day shifts and unregistered nurses on nights has deteriorated from June 2014 to May 2015. All other fill rate indicators are showing an improvement.

7.5 Springwood has been highlighted as having low staffing fill rates for registered nurses on day shifts, this is reporting at 58.2%.

## 8.0 Bank and Agency

8.1 The highest users of bank equated to 3 wards within the reporting period (Sandpiper, Cedar and Westerdale South).

8.2 The Central Bank Worker Service in their performance report have highlighted that their percentage fill rate has increased from 84.67% to 84.88%.

## 9.0 Quality Indicators

9.1 Triangulation of staffing data against level 4 and 5 incidents; complaints and control and restraint. The full analysis is outlined in full at appendix 1.

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

## 10.0 Contact Time

10.1 'Safer Staffing: A guide to care contact time' highlights the importance of drilling down further into levels of meaningful activity rather than a reliance on fill rates.

10.2 There are varying strands of work within the Trust being undertaken to assess this. A staffing contact time audit has been conducted which has highlighted deterioration in the time spent on direct care for qualified staff (from 37% to 34%).

10.3 A staffing capacity issue was identified in 1 AMH ward where 2 staff were caring for 8 patients was highlighted within the staffing contact time audit.

## 11.0 12 Hour Shift Review – MHSOP

11.1 A review of shift patterns within MHSOP Services in Durham & Darlington was undertaken in February and March 2015.

11.2 It was recommended that the 12 hour shift pattern remains in place and subject to a further review in December 2015.

## 12.0 Hard Truths Compliance and Census

12.1 Modern Matrons have confirmed that the daily staffing report, identification of named nurse and doctor near the bed of each individual patient is occurring.

12.2 In addition, Modern Matrons have confirmed that there are sufficient resources to safely manage the ward and provide therapeutic activities.

## 13.0 IMPLICATIONS / RISKS:

13.1 Quality: No risks or implications from the staffing data have been identified within the annual review.

13.2 Financial: It has been identified that there is little spare capacity in nursing establishments as they have been planned for maximum efficiency – it is therefore implied that the workforce deployment needs closer scrutiny to ensure those efficiencies do not constitute risks.

13.3 Legal and Constitutional: 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.

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

13.5 Other Risks: The current lack of an evidence based tool for workforce planning and monitoring in mental health and learning disability nursing increases the risk that the publication of the workforce data will be compared to other Trust's data without appreciation of context. Information published on the Trust website will assist with provision of contextual information. NHS England have taken over the work on safe staffing in Mental Health services which will establish what should be the right balance of staff and will be led by the Mental Health Taskforce. The rationale for the change will include factors such as the need to take into account all staff involved in mental health care, not just nurses, the importance of time spent with patients and their families, and the local variation in services.

## 14.0 CONCLUSIONS

14.1 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.

14.2 Work will be undertaken during next financial year 2015/16 which will refine the usage of the data further. The comparative analysis of complaints and incidents, particularly focussing on the areas where staff fell below the planned levels has not shown any significant trend or impact.

14.3 The 12 month average of staffing fill rates has identified 22 wards for registered nurses reporting a Red position whilst 6 wards for unregistered staff. Actions are taken to risk assess alternative solutions to provide overall safe staffing levels when the planned rosters could not or need not be delivered.

14.4 Work carried out by the clinical audit team has established that 34% of registered nurse time is spent on direct care which is a reduction on the previous audit whilst 76% of unqualified time is spent on direct care which was an increase on the previous audit. Changes are proposed to be made on PARIS providing more data on clinical activity which can be used to correlate with the staffing data.

## 15.0 RECOMMENDATION

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

15.2 It is proposed that the review framework and tools are piloted within certain areas of the organisation during quarter three of this financial year and a report presented to Board at that point as to future roll-outs.

**Emma Haimes, Head of Quality Data**
**Stephen Scorer, Deputy Director of Nursing**

**Appendix 1**

## Safe Staffing Report

### 1.0 Staffing and Establishments

1.1 It had been anticipated that there would be NICE guidance relating to safe staffing in Mental Health services later this year. This work has now been transferred to NHS England and the work on establishing what should be the right balance of staff is being led by the Mental Health Taskforce. A letter from the Chief Nursing Officer (11th June 2015) set out the rationale for the change which included factors such as the need to take into account all staff involved in mental health care, not just nurses, the importance of time spent with patients and their families, and the local variation in services which makes it difficult to apply a one size fits all approach.

1.2 As part of the Compassion in Practice (the 6C's of nursing) a mental health safe staffing framework has been devised. This is expected to feed into the Taskforce work on establishing staffing levels. The framework is available now as an interactive website, and includes suggested staffing calculation tools and some issues for Boards to consider. The website is available at this address http://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/06/mh-staffing-v4.pdf

1.3 Interestingly this guidance summarises some of the key differences between mental health and other NHS services when considering staffing levels, including that a higher proportion of actual interventions are required, and these are more likely to be reactive and unplanned.

1.4 The framework reports on the recent testing of staffing level calculation tools, in particular the Hurst Ward Multiplier tool. The first level of usage of this tool, to assist with local determination of staffing levels, is freely available via the website, with two higher levels of participation linked to national benchmarking also available at an additional cost. The tool takes clinical dependency levels of service users into account along with variables such as headroom, and generates a suggested establishment and skill mix. It is reported as sufficient to meet NQB safe staffing requirements at this level. The framework also points out that in addition to the use of these tools, Boards and managers need to exercise judgement, and there are ten indicators which it is suggested Boards take into account to assure themselves of the robustness of their staffing establishment calculations.

1.5 The framework also includes a suggested six step process for conducting a workforce review.

1.6 Boards will be aware that the Nursing and Governance Directorate has identified a workstream in the current annual business plan to review the safe staffing requirements, which initially included the aim of devising quality standards and measures for undertaking an establishment review. The framework appears to give the organisation a suggested way forward for a review which includes the use of evidence based tools for determining balanced staffing levels.

1.7 This therefore has required the original workstream scope to be revisited and the work will now report in Q4 2015/16.

1.8 The budgeted staffing establishments as at 1st June 2014 and the 31st May 2015 have been obtained from HealthRoster and have been used to compare the actual establishment in post, the findings are as follows:

- ***Durham & Darlington***

  - The budgeted establishment within Durham & Darlington for registered nurses in June 2014 was 135.9 compared to 143.0 In May 2015; this is an increase of 7.1WTE's. Actual registered nurses in post in June 2014 were 145.0 compared to 146.7 which is an increase of 1.75WTE's.

  - The budgeted establishment for unregistered staff in June 2014 was 210.8 compared to 226.6 in May 2015; this is an increase of 7.06 WTE's. Actual unregistered nurses in post as at 1st June 2014 was 213.6 compared to 211.4 in May 2015 which is a reduction of 2.18 WTE's.

  - An additional ward 'Harland' was added to the Durham and Darlington which has potentially distorted the figures. In addition the Section 136 Place of Safety unit attracted additional staffing resource from commissioners in this period.

    On further analysis the following is of importance when data is compared from 31st May 2015 to 1st June 2014:

    - Ceddesfeld have 6.56 less unregistered staff in post
    - Picktree have 2.37 less unregistered staff in post
    - Willow Ward have 2.32 less unregistered staff in post
    - Bek, Talbot and Ramsey have 2.31 less registered staff in post
    - Hamsterley have 2.20 less registered staff in post
    - Birch have 2.20 less registered staff in post
    - Maple have an additional 2 registered staff in post

- ***North Yorkshire***

  - The budgeted establishment within North Yorkshire for registered nurses in June 2014 was 118.7 compared to 120.4 In May 2015; this is an increase of 1.70WTE's. Actual registered nurses in post in June 2014 were 118.0 compared to 114.8 in May 2015 which is a deficit of 3.20WTE's.

- The budgeted establishment for unregistered staff in June 2014 was 134.6 compared to 153.6 in May 2015; this is an increase of 1.70 WTE's. Actual unregistered nurses in post as at 1st June 2014 was 150.0 compared to 153.8 in May 2015 this is an increase of 3.72 WTE's.

- The following is of importance:

  - Cedar (NY) has an increased budgeted establishment of 3.47WTE unregistered staff in May 2015 when compared to June 2014. Actual unregistered staff in post has increased from 8.55 to 14.0 WTE's.

  - Abdale House has seen an increased budgeted establishment for registered staff (from 5.86 to 10.73 in May 2015).

  - Rowan Lea has 2.80 less registered staff in post in May 2015 when compared to June 2014.

  - Westwood has seen an increased budgeted establishment of 2.48WTE registered staff in May 2015 when compared to June 2014.

  - Two new Section 136 Place of Safety units were commissioned with additional staffing of:

    Hambleton and Richmondshire;
    - 5.36 wte Band 6

    Harrogate;
    - 4.08 wte Band 3
    - 1.31 wte Band 6

    Scarborough;
    - 5.36 wte Band 6

- ***Forensic Services***

  - The budgeted establishment within Forensic Services for registered nurses in June 2014 was 212.9 compared to 186.6 in May 2015; this is a reduction of 26.3WTE's. Actual registered nurses in post in June 2014 were 197.6 compared to 176.8 in May 2015 which is a reduction of 20.75.

  - The budgeted established for unregistered staff in June 2014 was 400.9 compared to 387.2 in May 2015, this is a reduction of 26.26WTE's. Actual unregistered nurses in post as at 1st June 2014 was 361.2 compared to 345.5 in May 2015.

- The following is of importance:
    - Teal and Harland (in previous function) wards have closed which may be distorting the figures
    - A number of wards within FLD have seen a reduction in the budgeted establishment for registered nurses and an increase in unregistered nurse budgets. They are operating on 10.9 registered staff less than they are budgeted for.
    - Across FMH the budgets for registered nurses remain static when compared to June 2014.
    - Merlin and Sandpiper wards are operating on 2 less registered staff in May 2015 when compared to June 2014.
    - Brambling ward are operating on 3.10 less unregistered staff in May 2015 when compared to June 2014.
    - Linnett and Newtondale wards are operating on 2 more registered staff in May 2015 when compared to June 2014.

- ***Teesside***
    - The budgeted establishment within Teesside for registered nurses in June 2014 was 164.8 compared to 136.2 in May 2015; this is a reduction of 28.61 WTE's. Actual registered nurses in June 2014 were 164.6 compared to 137.9 in May 2015.
    - The budgeted established for unregistered staff in June 2014 was 281.8 compared to 239.1 in May 2015, this is a reduction of 28.61WTE's. Actual unregistered nurses in post as at 1st June 2014 was 244.3 compared to 217.4 in May 2015.
    - The following is of importance:
        - The Dales closed following the transfer of a patient. As a result a number of electronic rosters (The Lodge, Bankfields Court 3 & 4) merged to form one. These factors may be distorting the figures
        - Lustrum Vale are budgeted 4.4WTE less unregistered staff in May 2015 when compared to June 2014.
        - Lincoln Ward are budgeted 2.36WTE less registered staff in May 2015 when compared to June 2014.
        - Baysdale are budgeted 3.0WTE less registered staff in May 2015 when compared to June 2014.

- Westerdale North are budgeted 2.99WTE less unregistered staff in May 2015 when compared to June 2014.
- Overdale are operating on 2.96WTE less unregistered staff in post in May 2015 when compared to June 2014.
- Park House are operating on 2.20WTE less unregistered staff in post in May 2015 when compared to June 2014.

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

1.10 In line with the recent communication from NHS England which asks Trusts to take into account the whole staffing picture. Attached at appendix 3 is the budgeted establishment for the Multi-Disciplinary Team (MDT). This data advises that in June 2014 there were 90.93WTE budgeted posts which increased to 103.58WTE by May 2015.

1.11 New services that were commissioned in this period were:

| Cost Centre Name | Directorate |
|---|---|
| AMH TEES MENTAL HEALTH URGENT CARE CENTRE | TEESSIDE |
| CAMHS TEES ENHANCED CRISIS AND LIAISON TEAM | TEESSIDE |
| SUB M DURHAM CLINICAL TREATMENT | DURHAM AND DARLINGTON |
| OHC HMP DEERBOLT PRISON | FORENSIC SERVICES |
| OHC HMP DURHAM PRISON | FORENSIC SERVICES |
| OHC HMP FRANKLAND PRISON | FORENSIC SERVICES |
| OHC HMP HOLME HOUSE PRISON | FORENSIC SERVICES |
| OHC HMP LOW NEWTON PRISON | FORENSIC SERVICES |
| OHC HMP PRISON MANAGEMENT | FORENSIC SERVICES |
| OHC DURHAM L AND D | FORENSIC SERVICES |
| OHC MIDDLESBROUGH L AND D | FORENSIC SERVICES |
| OHC DARLINGTON L AND D | FORENSIC SERVICES |
| ALD D&D SPECIALIST HEALTH TEAM | DURHAM AND DARLINGTON |
| ALD LRH HARLAND REHAB | DURHAM AND DARLINGTON |
| AMH NY EATING DISORDERS | NORTH YORKSHIRE |
| AMH NY VULNERABLE VETERANS | NORTH YORKSHIRE |
| AMH NY IAPT | NORTH YORKSHIRE |
| MHSOP HAMB&RICH ACUTE HOS LIAIS | NORTH YORKSHIRE |
| MHSOP HARROGATE ACUTE HOS LIAIS | NORTH YORKSHIRE |
| MHSOP SCARBOROUGH ACUTE HOS LIAIS | NORTH YORKSHIRE |

## 2.0 Workforce Variances

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

- 12 wards who had maternity absence greater than 5% loss of the actual hours
- 53 wards who had sickness absence rates greater than 5% loss of actual hours
- 24 wards who had vacancies greater than 10% loss of actual hours
- 8 wards who had bank usage greater than 39.9% loss of actual hours worked
- 2 wards who had agency and overtime greater than 4% loss of actual hours

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

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

| Month | Number of duties | Number of hours |
|---|---|---|
| June | 1186 | 12,306 |
| July | 1270 | 12,828 |
| August | 1147 | 11,897 |
| September | 839 | 8,746 |
| October | 1000 | 10,049 |
| November | 1086 | 11,269 |
| December | 1059 | 10,981 |
| January | 1216 | 12,525 |
| February | 1147 | 11,972 |
| March | 1177 | 12,371 |
| April | 878 | 9,576 |
| May | 905 | 9,990 |
| | 12910 | 134,510 |

- This table highlights a fluctuating picture per month of the number of additional duties being created.
- 1,186 additional duties were created in June 2014 and only 905 duties created in May 2015, this is a reduction of 281 duties.

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

| Ward / Team | Number of Duties | Number of Hours |
|---|---|---|
| Sandpiper | 1,599 | 17,795 |
| Westerdale South | 1,376 | 12,382 |
| Mallard | 983 | 10,878 |
| Cedar Ward | 655 | 7,701 |
| Birch Ward | 667 | 6,862 |
| Cedar (NY) | 624 | 5,623 |
| Westwood Centre | 581 | 5,297 |

## 3.0 Occupancy Rates

3.1 When considering staffing it is useful to triangulate this to the occupancy rates to further understand whether any correlation exists.

3.2 Looking at those wards whose occupancy rates are 100% or more and to compare this to the staffing fill rate and bank usage the findings are as follows:

| | 12 Months - 1st June 2014 to 31st May 2015 | | | | | | Bank Usage Vs Actual Hours | |
|---|---|---|---|---|---|---|---|---|
| | | | RN Average % | | Unregistered Average % | | | |
| Known As | Occupied bed days | Bed Usage as a % | Day | Night | Day | Night | Hours | % against Actual Hours |
| Bilsdale | 5278 | 103.29 | 86.7% | 100.8% | 112.3% | 100.2% | 3858.25 | 12.55% |
| Ward 15 | 4478 | 102.24 | 75.1% | 104.5% | 121.7% | 99.0% | 7135.68 | 21.80% |
| Harrier/Hawk | 2311 | 105.53 | 77.1% | 106.3% | 82.7% | 92.4% | 5944.85 | 15.22% |
| The Lodge | 365 | 100.00 | 92.9% | 89.7% | 89.9% | 92.6% | 1295.86 | 6.35% |
| Westerdale North | 6575 | 100.08 | 101.3% | 101.4% | 126.2% | 113.4% | 4137.75 | 11.99% |
| Westerdale South | 5145 | 100.68 | 101.6% | 101.1% | 200.0% | 175.9% | 23846.76 | 52.51% |
| Oak Ward | 4423 | 100.98 | 91.3% | 100.3% | 97.5% | 99.4% | 743.79 | 2.37% |

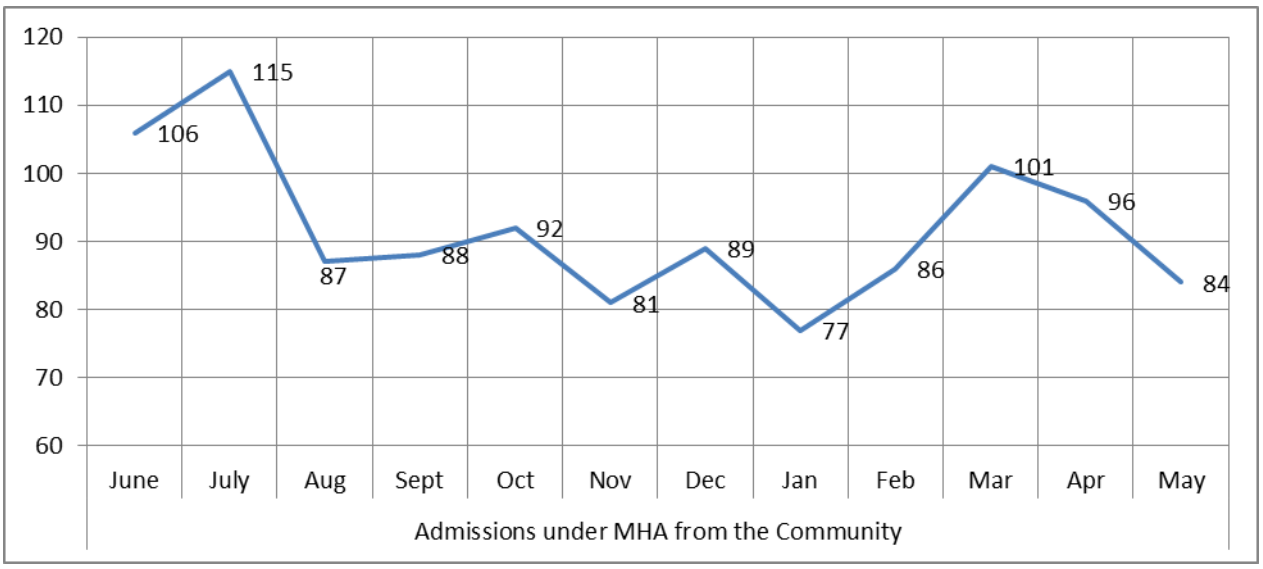
- Where the occupancy rates are high there is an assumption that more staff may be required, this is not the case from the snapshot highlighted above.
- With the exception of Westerdale South it is not clear from the above table that there would be a greater need for bank where occupancy levels are high.

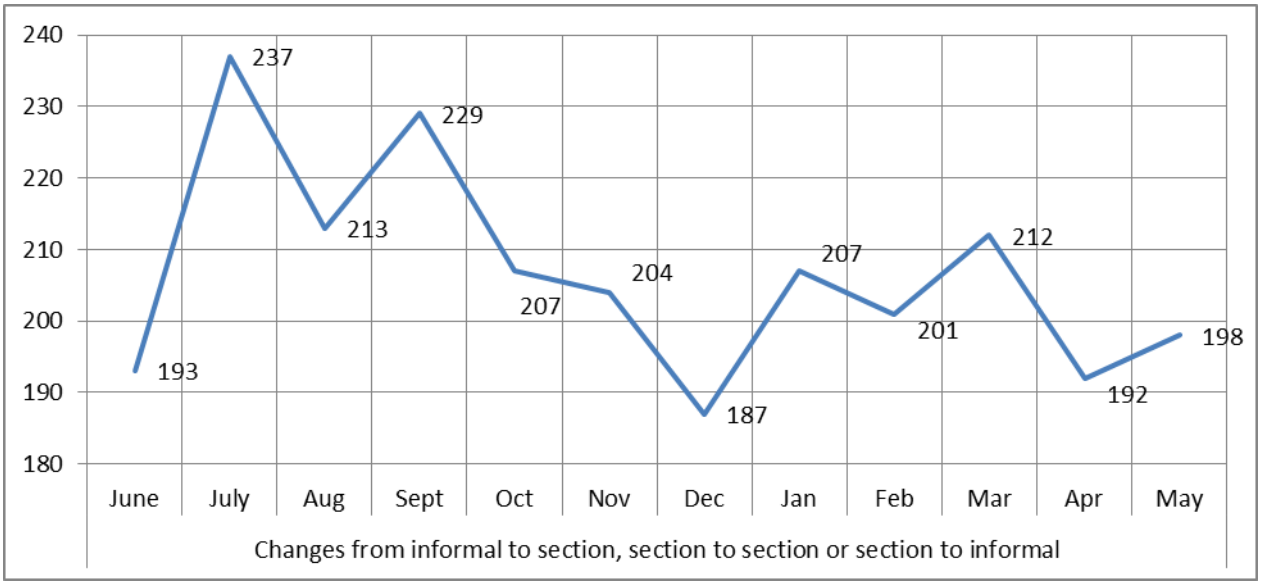
3.3 Appendix 5 of this report contains all occupancy rates as a percentage by speciality and ward.

## 4.0 Mental Health Act Activity

4.1 We have also took into account Mental Health Act activity to determine whether there had been an increased impact on staffing levels during the reporting period in light of the Cheshire West ruling and related factors.

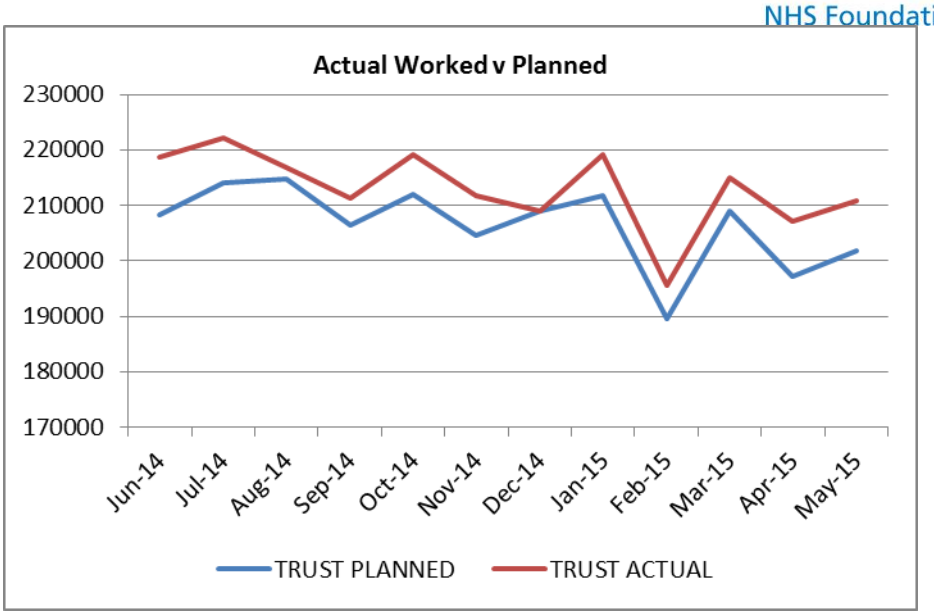
4.2 The graphs below provides a summary of the mental health act activity over the past 12 months which suggests varying levels of activity across the year from which it is difficult to draw any meaningful conclusions as to the impact on safe staffing levels.




## 5.0 Planned versus Actual Hours Worked

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




5.2 It is important to highlight that December 2014 was the only occasion whereby the actual hours worked mirrored what was planned. All other months show the actual hours worked exceeding the planned.

5.3 Appendix 6 of the report shows the average fill rate (June 2014 to May 2015) for both days and nights for both registered and non-registered.

5.4 The annual position shows that there were 22 wards who had fill rates of less than 89.9% (shown as red) for registered nurses on daytime shifts. For health care assistants on daytime shifts there were 6 wards with a fill rate below 89.9%.

5.5 In terms of the night time shifts the annual position shows that there were 6 wards who had fill rates of less than 89.9% (shown as red) for registered nurses. For health care assistants on nights there was only 1 ward who had a fill rate below 89.9%.

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

| Month | Draft Submission | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Day | | | | Night | | | |
| | Average Fill Rate - Registered Nurses / Midwives (%) | Trend on Prev Month | Average Fill Rate - Care Staff (%) | Trend on Prev Month | Average Fill Rate - Registered Nurses / Midwives (%) | Trend on Prev Month | Average Fill Rate - Care Staff (%) | Trend on Prev Month |
| Jun-14 | 94.15 | ↑ | 109.00 | ↑ | 100.80 | ↑ | 113.00 | ↑ |
| Jul-14 | 90.75 | ↓ | 110.00 | ↑ | 99.68 | ↓ | 111.00 | ↓ |
| Aug-14 | 85.75 | ↓ | 107.14 | ↓ | 99.60 | ↓ | 109.00 | ↓ |
| Sep-14 | 92.99 | ↑ | 105.27 | ↓ | 99.67 | ↑ | 109.43 | ↑ |
| Oct-14 | 92.63 | ↓ | 108.82 | ↑ | 99.09 | ↓ | 108.67 | ↓ |
| Nov-14 | 91.84 | ↓ | 109.38 | ↑ | 99.41 | ↑ | 108.98 | ↑ |
| Dec-14 | 90.79 | ↓ | 102.47 | ↓ | 98.22 | ↓ | 107.13 | ↓ |
| Jan-15 | 92.54 | ↑ | 105.31 | ↑ | 98.91 | ↑ | 108.42 | ↑ |
| Feb-15 | 92.65 | ↑ | 107.14 | ↑ | 102.52 | ↑ | 109.17 | ↑ |
| Mar-15 | 91.99 | ↓ | 106.64 | ↓ | 100.62 | ↓ | 110.48 | ↑ |
| Apr-15 | 93.12 | ↑ | 111.42 | ↑ | 101.19 | ↑ | 111.20 | ↑ |
| May-15 | 93.00 | ↓ | 110.34 | ↓ | 102.27 | ↑ | 110.09 | ↓ |

From the table it is important to highlight the following:

- The average fill rate for registered nurses on day shifts has deteriorated from 94.15% in June 2014 compared to 93% in May 2015 (1.15% decrease).
- The average fill rate for health care assistants on day shifts has improved from 109% in June 2014 to 110.34 in May 2015 (1.34% improvement).
- The average fill rate for registered nurses on night shifts has improved from 100.80% in June 2014 compared to 102.27% in May 2015 (1.47% improvement)
- The average fill rate for health care assistants on night shifts has deteriorated from 113% in June 2014 to110.09 in May 2015.

5.7 The overall total red rated occurrences utilising the average fill rate (i.e. less than 89.9%) was 34 wards. The table below shows the breakdown by locality:

| Locality | Total number of Red Wards |
|---|---|
| Durham & Darlington | 3 |
| Teesside | 12 |
| North Yorkshire | 4 |
| Forensic Services | 15 |

- Forensic and Teesside services have the highest number of red wards across the reporting period.

5.8 The 12 month average for The Dales for RN on day shifts is recorded at 54.4%, along with an unregistered fill rate on day shifts at 57.4%. The Dales cannot be highlighted as an outlier within this annual report due to the unit closing prior to the end of the 12 month period therefore this is not a true average.

5.9 The monthly reports have consistently highlighted Springwood as having low staffing fill rates for RN on day shifts, the 12 month average for Springwood is reporting at 58.2%. It is important that further monitoring of this position continues within the monthly reports triangulating where possible with bank, agency and other quality metrics.

5.10 The following wards are also showing red utilising the 12 month average as follows:

| Ward | Red Fill Rate | Comments |
|---|---|---|
| Abdale House | 72.7% for HCA on days | Historically Abdale have reported the use of bank to back fill any shortfall |
| Ward 15 | 75.1% for RN on days | Ward 15 has historically reported that they have used health care assistants to back fill any shortfall. This is evidenced within the 12 month average HCA figure for days (121.7%) |
| Harrier / Hawk | 77.1% for RN on days | Historically harrier / hawk have advised that they have seen a reduction of patients on occasions, sickness and vacancies as contributory factors for the shortfall. |
| Langley | 78.6% for RN on days | Langley have historically reported that any shortfall was due to vacancies and sickness. A reduction of beds was also highlighted in May 2015. |

## 6.0 Bank and Agency

6.1 Appendix 6 also highlights the use of bank staffing as a proportion of actual hours worked averaged over the 12 month period. These are 'RAG' rated independently of the overall fill rate. Those wards using greater than 50% bank staffing to deliver their fill rates are identified below:

| **Locality** | **Ward** | **Bank Usage %** |
|---|---|---|
| Forensic Services | Sandpiper | 61.28% |
| Durham & Darlington | Cedar | 55.45% |
| Teesside | Westerdale South | 52.51% |

- This equates to 3 wards within the reporting period in a range of localities

6.2 49 wards were reported as Amber and 12 wards were reported as Green.

6.3 The monthly report monitors the use of bank usage due to the risks that high use of bank staffing can have on a ward or team. This is however, 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. Bank workers must have the required competencies assessed and passed before being permitted to carry out work within a particular ward or team.

6.4 The Central Bank Worker Service produced a performance report in April 2015 which provided the following a summary of their performance:

| | 2013/14 | 2014/15 |
|---|---|---|
| Total Bank Worker demand/usage | 43620 | 46921 |
| Bank worker training | 2925 | 2269 |
| Ward shifts requested | 40695 | 44652 |
| Number filled | 34458 | 37900 |
| Number unfillable | 6237 | 6752 |
| % fill rate | 84.67% | 84.88% |

- The above table identifies that there was an increase of 4000 ward requests in 2014/15 compared to the previous year. Whilst the percentage fill rate has not increased significantly, the Central Bank Worker Service has filled an additional 3500 shifts in 2014/15 compared to the previous year.

6.5 Key issues identified from the bank performance report include:

- Durham & Darlington are to pilot a 'floater' model whereby nursing and HCA staff are deployed to cover shifts at short notice with a view to reduce overtime spend and staffing issues caused by short term sickness. It is understood that proposals are being developed for consideration during the autumn of 2015.

- Shifts in North Yorkshire, particularly in MHSOP are difficult to cover. Although this has improved during 2014/15, we are still experiencing difficulties in recruiting in the North Yorkshire locality. A recruitment event will be held in July in North Yorkshire to try and attract more people to the Trust.

- Observation and engagement competencies have been introduced and we are working towards a high level of compliance. This has enabled wards to request a particular skill when requesting a shift so that observation or escort duties are not allocated to a bank worker without the appropriate skill set.

- Induction arrangements have been changed which is working well and the bank HCA training framework is now embedded. Supervision arrangements need to be strengthened and there are plans to look at this in the next year.

- Registered nurses continue to be difficult to attract to the bank, the majority of our nurses being existing staff with second assignments.

6.6 We have not attached to this report a copy of the Central Bank Worker Service this is however, available upon request.

## 7.0 Quality Indicators

7.1 In turning to the triangulation of staffing data with other safety indicators at appendix 7 an overview can be found of all quality indicators. Firstly there were 11 level 5 patient safety incidents occurring in in-patient areas within the 12 month period. These are summarised below utilising the bank fill rate and staffing fill rates as comparative data:

| No. of L5 Incidents | Ward | Bank fill rate | Staffing Fill Rates | | | |
|---|---|---|---|---|---|---|
| | | | RN Days | HCA Days | RN Nights | HCA Nights |
| 1 | Mallard | 47.82% | 101.0% | 102.5% | 122.7% | 175.7% |
| 1 | Birch | 47.17% | 87.2% | 97.0% | 123.9% | 144.2% |
| 1 | Maple | 25.25% | 94.9% | 101.7% | 112.9% | 118.4% |
| 1 | Esk Ward | 23.18% | 92.9% | 109.9% | 104.0% | 91.9% |
| 1 | Newtondale | 17.64% | 91.6% | 86.2% | 91.7% | 101.7% |
| 1 | Bilsdale | 12.55% | 86.7% | 100.8% | 112.3% | 100.2% |
| 2 | Farnham | 10.37% | 101.9% | 99.7% | 112.2% | 104.5% |
| 1 | Tunstall | 3.77% | 100.8% | 99.9% | 126.8% | 104.2% |
| 1 | Oak | 2.37% | 91.3% | 100.3% | 97.5% | 99.4% |
| 1 | Wingfield | 0.91% | 83.4% | 99.7% | 94.6% | 101.4% |

- Within the 12 months Birch have had a Level 5 incident and a red bank fill rate of 47.17%. When compared to the staffing fill rates Birch are showing a red for RN days and staffing levels that are either green or blue for the remainder metrics.
- Mallard ward have also had a level 5 incident and a red bank fill rate of 47.82%. When correlated to the staffing levels all metrics are showing that the staffing exceeds the budgeted establishments across all metrics.
- Maple, Bilsdale, Esk and Newtondale have all had a level 5 incident and are all showing amber for their bank fill rates. With the exception of Bilsdale and Newtondale all are categorised as green for their staffing fill rates.
- Tunstall, Farnham, Wingfield and Oak all have had a level 5 incident and are all showing green for their bank fill rates. All have staffing fill rates with the exception of Wingfield that are either green or blue.

7.2 There were a total of 51 Level 4 incidents within the reporting period. These are summarised below utilising the bank fill rate and staffing fill rates as comparative data:

| No. of L4 Incidents | Ward | Bank fill rate | Staffing Fill Rates | | | |
|---|---|---|---|---|---|---|
| | | | RN Days | HCA Days | RN Nights | HCA Nights |
| 1 | Tunstall Ward | 3.77 | 100.8 | 99.9 | 126.8 | 104.2 |
| 1 | Maple | 25.25 | 94.9 | 101.7 | 112.9 | 118.4 |
| 2 | Primrose | 12.15 | 94.8 | 102.3 | 102.6 | 101.1 |
| 1 | Lincoln | 17.15 | 105.1 | 102.6 | 98.4 | 106.7 |
| 2 | Stockdale | 25.14 | 92.5 | 102.9 | 117.7 | 109.1 |
| 2 | Bransdale | 23.95 | 93.0 | 100.8 | 105.6 | 101.1 |
| 2 | Bilsdale | 12.55 | 86.7 | 100.8 | 112.3 | 100.2 |
| 1 | Cedar (NY) | 23.28 | 101.5 | 110.9 | 127.9 | 156.3 |
| 1 | Esk Ward | 23.18 | 92.9 | 109.9 | 104.0 | 91.9 |
| 1 | Danby Ward | 18.91 | 108.8 | 91.1 | 93.1 | 90.1 |
| 1 | Westwood | 25.9 | 102.2 | 109.6 | 122.4 | 116.7 |
| 1 | Newberry | 10.57 | 94.7 | 106.0 | 102.9 | 106.3 |
| 2 | Clover / Ivy | 22.98 | 103.4 | 106.9 | 94.2 | 106.9 |
| 1 | Harrier / Hawk | 15.20 | 77.1 | 106.3 | 82.7 | 92.4 |
| 1 | Mallard | 47.82 | 101.0 | 102.5 | 122.7 | 175.7 |
| 2 | Northdale | 42.24 | 99.1 | 105.8 | 98.3 | 107.8 |
| 1 | Fulmar | 33.99 | 89.5 | 103.3 | 112.8 | 133.5 |
| 2 | Jay | 15.73 | 78.0 | 100.2 | 104.4 | 100.1 |
| 1 | Nightingale | 16.97 | 85.0 | 100.9 | 108.1 | 102.8 |
| 2 | Sandpiper | 61.28 | 93.9 | 85.1 | 131.6 | 222.5 |
| 1 | Swift | 25.92 | 87.8 | 101.3 | 100.2 | 113.2 |
| 6 | Kirkdale | 22.5 | 89.4 | 102.4 | 97.3 | 99.2 |
| 3 | Mandarin | 13.74 | 87.8 | 104.3 | 99.7 | 98.1 |
| 2 | Newtondale | 17.64 | 91.6 | 86.2 | 91.7 | 101.7 |
| 1 | Westerdale South | 52.51 | 101.6 | 101.1 | 200.0 | 175.9 |
| 1 | Westerdale North | 11.99 | 101.3 | 101.4 | 126.2 | 113.4 |
| 1 | Picktree | 27.81 | 96.4 | 99.7 | 135.0 | 118.76 |
| 1 | Oak Ward | 2.37 | 91.3 | 100.3 | 97.5 | 99.4 |
| 1 | Roseberry | 11.42 | 95.0 | 92.3 | 100.5 | 100.1 |
| 2 | Rowan | 17.71 | 95.7 | 138.2 | 102.4 | 109.5 |
| 1 | Ward 14 | 0.54 | 82.0 | 105.4 | 110.5 | 105.2 |
| 2 | Springwood | 12.42 | 58.6 | 99.5 | 197.7 | 135.7 |
| 1 | Rowan Lea | 3.98 | 97.3 | 110.0 | 97.6 | 94.1 |

- Kirkdale is an outlier regarding number of L4 incidents with also an amber and red position on staffing.

- Mallard, Northdale, Sandpiper and Westerdale North all had level 4 incidents during the reporting period and all had red bank fill rates. However there staffing fill rates were either within the tolerance of a 'green' or staffing levels in excess of the budgeted establishment.

- Harrier / Hawk had 1 level 4 incident during the reporting period and showed 'amber' for their bank fill rate. They also had 2 metrics within the staffing fill rates that were classified as 'red' whilst the other metrics were identified as 'green'.

- Bilsdale, Fulmar, Jay, Nightingale, Swift, , Mandarin, Newtondale,Ward 14 and Springwood all had level 4 incidents during the reporting period and showed amber for their bank fill rate. They also had 1 metric within the staffing fill rates that was classified as 'red' whilst the remaining metrics were green or blue.

- Tunstall, Oak, Ward 14 and Rowan all had level 4 incidents during the reporting period and showed 'green' for their bank fill rates. With the exception of Ward 14 all remaining wards were 'green' for their staffing fill rates.

7.3 There were 81 complaints raised during the reporting period. These are summarised below utilising the bank and staffing fill rates as comparative data:

| No. of Complaints | Ward | Bank fill rate | Staffing Fill Rates | | | |
|---|---|---|---|---|---|---|
| | | | RN Days | HCA Days | RN Nights | HCA Nights |
| 1 | Lark | 16.40% | 84.8% | 101.8% | 110.0% | 99.6% |
| 2 | Mandarin | 13.74% | 87.8% | 104.3% | 99.7% | 98.1% |
| 2 | Newtondale | 17.64% | 91.6% | 86.2% | 91.7% | 101.7% |
| 1 | Unit2 | 29.62% | 128.7% | 101.1% | 104.2% | 106.2% |
| 2 | Bek, Talbot & Ramsey | 10.93% | 96.9% | 101.9% | 101.6% | 103.9% |
| 1 | Westerdale South | 52.51% | 101.6% | 101.0% | 200.0% | 175.9% |
| 3 | Westerdale North | 11.99% | 101.3% | 101.4% | 126.2% | 113.4% |
| 1 | Wingfield | 0.91% | 83.4% | 99.7% | 94.6% | 101.4% |
| 1 | Picktree | 27.81% | 96.4% | 99.7% | 135.0% | 118.7% |
| 1 | Roseberry | 11.42% | 95.0% | 92.3% | 100.5% | 100.1% |
| 2 | Rowan | 17.71% | 95.7% | 138.2% | 102.4% | 109.5% |
| 1 | Ward 14 | 0.54% | 82.0% | 105.4% | 110.5% | 105.2% |
| 1 | Tunstall | 3.77% | 10.8% | 99.9% | 126.8% | 104.2% |
| 2 | Farnham | 10.37% | 101.9% | 99.7% | 112.2% | 104.5% |
| 2 | Elm | 20.25% | 100.6% | 101.4% | 113.9% | 109.2% |
| 2 | Birch | 47.17% | 87.2% | 97.0% | 123.9% | 144.2% |
| 5 | Maple | 25.25% | 94.9% | 101.7% | 112.9% | 118.4% |
| 2 | Cedar | 55.45% | 73.7% | 88.8% | 134.4% | 123.9% |
| 2 | Stockdale | 25.14% | 92.5% | 102.9% | 117.7% | 109.1% |
| 1 | Bransdale | 23.95% | 93.0% | 100.8% | 105.6% | 101.1% |
| 1 | Lustrum Vale | 19.47% | 85.8% | 107.9% | 122.0% | 102.4% |
| 3 | Bilsdale | 12.55% | 86.7% | 100.8% | 12.3% | 100.2% |
| 1 | Bedale | 32.17% | 84.2% | 101.9% | 136.0% | 111.3% |
| 1 | Park House | 37.76% | 95.1% | 101.4% | 105.4% | 101.9% |

| | | | | | | |
|---|---|---|---|---|---|---|
| 2 | Overdale | 22.78% | 81.0% | 97.8% | 112.7% | 102.5% |
| 5 | Cedar (NY) | 23.28% | 101.5% | 110.9% | 127.9% | 156.3% |
| 3 | Ward 15 | 21.8% | 75.1% | 104.5% | 121.7% | 99.0% |
| 5 | Esk Ward | 23.18% | 92.9% | 109.9% | 104.0% | 91.9% |
| 1 | Westwood | 25.9% | 102.2% | 109.6% | 122.4% | 116.7% |
| 3 | Newberry | 10.57% | 94.7% | 106.0% | 102.9% | 106.3% |
| 1 | Eagle / Osprey | 40.22% | 100.8% | 100.9% | 97.2% | 103.6% |
| 2 | Kingfisher/Heron/ Robin | 23.98% | 94.8% | 105.8% | 98.2% | 95.5% |
| 3 | Harrier / Hawk | 15.22% | 77.1% | 106.3% | 82.7% | 92.4% |
| 2 | Mallard | 47.82% | 101.0% | 102.5% | 122.7% | 175.7% |
| 2 | Northdale | 42.24% | 99.1% | 105.8% | 98.3% | 107.8% |
| 2 | Brambling | 45.2% | 92.8% | 101.3% | 114.1% | 135.3% |
| 2 | Merlin | 36.57% | 95.0% | 89.8% | 125.0% | 135.5% |
| 2 | Fulmar | 33.99% | 89.5% | 103.3% | 112.8% | 133.5% |
| 1 | Sandpiper | 61.28% | 93.9% | 85.1% | 131.6% | 222.5% |
| 2 | Kirkdale | 22.5% | 89.4% | 102.4% | 97.3% | 99.2% |

- Cedar ward had a complaint and had a ‘red’ bank fill rate. In terms of the staffing fill rates there were 2 indicators that were red and all other exceeded the budgeted establishment.
- Birch and Sandpiper had complaints during the reporting period and had a ‘red’ bank fill rate. With regards to the staffing fill rates they showed ‘red’ for one indicator whilst all others were either green or blue.
- Westerdale South, Mallard, Northdale and Brambling had complaints during the reporting period and had a ‘red’ bank fill rate. All other staffing fill rates for these areas were either ‘green’ or ‘blue’.
- Harrier / Hawk had a complaint and also had an ‘amber’ bank fill rate in addition to 2 staffing fill rate indicators also showing as ‘red’.
- Lark, Mandarin, Newtondale, Lustrum Vale, Bilsdale, Bedale, Overdale, Ward 15, Merlin, Fulmar and Kirkdale all had complaints and an ‘amber’ bank fill rate. In terms of the staffing fill rates all showed ‘red’ for at least one of the fill rate indicators.
- All those that showed as ‘amber’ on the bank fill rate had either green or blue staffing fill rates.
- Wingfield and Ward 14 although they had a ‘green’ bank fill rate they had at least one indicator on the staffing fill rates that were ‘red’.
- Tunstall although they had a complaint in the reporting period they showed as ‘green’ in terms of all other fill rate indicators.

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

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

| Ward | Locality | Incidents of Restraint | | | | Bank Usage |
|---|---|---|---|---|---|---|
| | | Incidents | PRO used | Other | Restraint Total | |
| Westwood | North Yorkshire | 693 | 181 | 1242 | 1423 | 25.9% |
| Evergreen | North Yorkshire | 339 | 24 | 607 | 631 | 25.55% |
| Newberry | North Yorkshire | 312 | 46 | 485 | 531 | 10.57% |
| Fulmar | Forensic Services | 255 | 74 | 439 | 513 | 33.99% |
| Bankfields 3&4 | Teesside | 301 | 18 | 392 | 410 | 21.29% |
| Thistle | Forensic Services | 179 | 36 | 337 | 373 | 21.58% |
| Sandpiper | Forensic Services | 149 | 27 | 315 | 342 | 61.28% |
| Swift | Forensic Services | 177 | 28 | 284 | 312 | 25.92% |
| Bedale | Teesside | 140 | 20 | 182 | 202 | 32.17% |
| Cedar | Durham & Darlington | 85 | 50 | 135 | 185 | 55.45% |

- Westwood had 693 incidents of restraints during the reporting period with 181 episodes of Prone used and 1242 were classified as other types of restraints. In addition they also had an amber bank fill rate.

- All other wards with the exception of Sandpiper and Thistle although they did have incidents that resulted in the use of restraint their totals were over half that of Westwood. They did all have an 'amber' bank fill rate.

- Although Sandpiper and Thistle had fewer incidents which resulted in the use of restraint they did have a 'red' bank fill rate.

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

| | Day | | Night | |
|---|---|---|---|---|
| Ward | Fill rate between planned and actual (Registered) | Fill rate between planned and actual (HCA) | Fill rate between planned and actual (Registered) | Fill rate between planned and actual (HCA) |
| Westwood | 102.2% | 109.6% | 122.4% | 116.7% |
| Evergreen | 92.4% | 102.4% | 123.7% | 113.6% |
| Newberry | 94.7% | 106.0% | 102.9% | 106.3% |
| Fulmar | 89.5% | 103.3% | 112.8% | 135.5% |
| Bankfields 3&4 | 92.0% | 94.5% | 100.3% | 98.2% |
| Thistle | 81.7% | 107.1% | 109.2% | 116.2% |
| Sandpiper | 93.9% | 85.1% | 131.6% | 222.5% |
| Swift | 87.8% | 101.3% | 100.2% | 113.2% |

| | | | | |
|---|---|---|---|---|
| Bedale | 84.2% | 101.9% | 136.0% | 111.3% |
| Cedar | 73.7% | 88.8% | 134.4% | 123.9% |

7.7 With regards to the use of Prone restraint this will continue to be monitored within the Force reduction project and monthly within the Safe Staffing reports however, it is worth highlighting that during the reporting period there were 686 episodes of Prone used.

## 8.0 Contact Time

8.1 In addition to the initial requirements based on reporting of staffing fill rates, the NHS recently produced further guidance 'Safer Staffing: A guide to care contact time'. This guidance highlighted the importance of ensuring patients are receiving the nursing care and contact time they need. It highlighted the need to go beyond simple numbers and fill rates and drill down further into levels of meaningful activity. No national targets for contact time have been set as it is recognised that high contact time in itself is not necessarily an indicator of quality if it means that other tasks such as communication and discharge planning are being overlooked. It is possible that contact time can be high on a ward which is staffed at a lower level for these reasons. Therefore Trusts are being asked to determine whether contact time is in line with their expectations and quality focus rather than have a National target.

8.2 Within the Trust there are various strands of work which aim to address this point:

- Staffing contact time audit. In line with the guidance this uses elements of the productive ward series approach to sample the range of activity which registered nurses and health care assistants undertake. This is the third cycle of the audit that the Trust has engaged in to date. The findings are outlined further below.

- Changes are being made to the PARIS system to enable recording of categories of clinical activity on the wards, as was previously available for community based tams. This is in pilot stage at present and data will be reported upon as data is available.

- Some observational studies have been carried out within Forensic Services by the KPO office who have shadowed a number of nurses during their 12 hour shift within Forensic Services. Brief findings will be presented below.

8.3 With regards to the staffing contact time audit which was conducted in order to gather information about how qualified and unqualified staff utilise their time on the wards over a given time period. Data was gathered during May 2015 utilising the same methodology which was used in 2014.

The observation of practice was conducted on 20 wards as follows:

| Locality | D&D | Tees | NYK | Forensic |
|---|---|---|---|---|
| No. of wards | 8 | 4 | 5 | 3 |
| No. of staff | 16 | 8 | 10 | 6 |
| % of total | 40% | 20% | 25% | 15% |

8.4 On each ward a qualified and unqualified member of staff was observed for an hour with their activity recorded at one minute intervals. This gave 40 1 hour samples. Activity was allocated to 18 categories of Direct Care Time and 16 categories of Non Direct Care Time. These were summarised into 4 categories of Direct care Time and 8 categories of Non Direct care Time. In addition to the categories on the audit tool, "Other" categories were added for both Direct Care Time and Non Direct Care Time where the auditor was unable to satisfactorily categorise the activity.

8.5 The following pages summarise the May 2015 results for all staff. Breakdowns are available for localities and specialties if required although the number of staff observed will be fewer.

- Qualified staff overall spent 34% of their time on direct care and 66% on non-direct care. In the previous 2014 audits the figures were 37% and 35% on direct care and 63% and 65% on non-direct care.

- Unqualified staff overall spent 76% of their time on direct care and 24% on non-direct care. In the previous 2014 audits the figures were 74% and 66%% on direct care and 26% and 34% on non-direct care.

8.6 The report also highlighted a staffing capacity In one AMH ward which appeared to be an issue with 2 staff caring for 8 patients some of whom were unsettled. The auditor observed patients smoking unsupervised in the garden and 1 patient commented that a lack of staffing frequently prevented patients going on escorted leave.

8.7 A copy of the report has not been included within the appendices of this report however, this is available upon request. Attached at appendix 8 is a copy of the results for all staff following the ward observation exercise.

8.8 A literature review carried out in 2010 stated at best 50% of staff time in Mental Health inpatient units is spent with patients with lower levels of this spent on lower levels of therapeutic activity.

8.9 Further within the NHS contact time, studies were reported upon which highlighted contact time varying between 38 and 61% for registered nurses and 64 to 86% were health care assistants. The pilot however featured one mental health trust alongside 13 acute trusts. There is insufficient detail in the reports to compare methodologies and criteria used.

## 9.0 12 Hour Shift Review - MHSOP

9.1 A review of shift patterns within MHSOP Services in Durham & Darlington was undertaken in February and March 2015 with a review planned for December 2015.

9.2 The review involved all staff working on the wards to complete a questionnaire and visits were undertaken on both shifts (days and nights)

9.3 46 completed questionnaires were received from ward based staff and 6 from non-ward based staff, these were all from medical staff.

9.4 The conclusions are as follows:

- The 12 hour shifts have now been in place for 6 months across all in patient areas, the previous shift pattern was in place over many years.
- Staff reported tiredness and mental fatigue, particularly on the organic assessment/challenging behaviour wards, more-so when carrying our 3 or more consecutive day shifts. The only issue staff reported on night duty was the earlier start ("getting ready to leave the house early") but generally accepted that night duties were not "significantly" longer. The process to support staff getting a break (2 x 20 minutes or 1 x 40 minutes) needs to be better implemented. (Recognising the clinical pressures and staff numbers can be this difficult).
- With more refined processes to manage use of non-clinical staff to locate additional staff when required (this is known to take up a great deal of time) and other non-clinical duties we can support staff to focus on patient needs. These issues are not directly related to 12 hour shifts but impact on the stresses staff have while on duty.
- Managers were managing additional duties (including covering absences) by breaking the day down in to half days occasionally which was resolving some of the difficulties as while staff were willing to work some additional hours they do not always want to work 12 hours. As further staffing changes have also taken place all the inpatient areas (at the time of this report) had all vacancies filled.
- Due to the 12 hour shifts staff are on duty less often and therefore need methods of ensuring they are up to date and have good recent intelligence about where each patient's wellbeing and plans for discharge. Support to patient's and carers through some consideration to the named nurse system will be required as currently named nurses may not see patient's or their carers for several days.
- Any staff who have health issues that directly relate to 12 hour shifts should be supported by their ward manager and reviewed by occupational health if required. All staff that required flexible arrangements to be considered had this done at the beginning of the process, all reported to be happy with the agreement put in place. The flexible working policy indicates that staff should raise any changes in their circumstances with their line manager, there have been no requests since the implementation of the 12 hour shifts.
- The 12 hour shifts need more time to be bedded into practice and consideration to addressing the communication and support mechanisms for staff. (See action plan for details)
- Further changes to bed numbers and establishments for wards have been agreed since this review**.**

9.5 It was recommended that the 12 hour shift pattern remains in place and is included as part of any further review, planned for after December 2015, of the inpatient services provided by Durham & Darlington MHSOP services

## 10.0 Hard Truths Compliance and Census

10.1 Modern Matron's across the trust were contacted asking for confirmation that the daily staffing report, identification of named nurse and doctor near the bed of each individual patient was occurring. 10 individuals responded covering in excess of 34 wards and all advised that they were complying with this requirement. The AMH Durham and Darlington Rehab and Recovery Services advised that they were also providing information in relation to the Unit Manager and Modern Matron as well as providing a description of the roles.

10.2 In addition, the Modern Matrons were asked to answer "are there the resources to safely manage the ward and provide required therapeutic activities?"

The responses received all confirmed that 'yes' they do have the required resources to safely manage the ward and provide therapeutic activity. The following was also provided:

- There are some occasions when we do not in my opinion. But this is on a rare occasion of exceptionally high clinical acuity when central bank has been unable to fulfil our requests and overtime has not been taken up.
- There has been occasions when the Ward Manager has covered as the second qualified but this has not compromised safety and have had enough staff to carry out activities, leaves etc.
- We have employed occupational therapists and assistants to support therapeutic activities
- There are times when activity may need to be cancelled as a consequence of individual patient need, generally as a result of relapse in mental and physical state necessitating increased input by nursing staff to individual patients. Although at these times, management of the situation to maintain a safe and therapeutic environment is sought with staff from other units, bank or in extreme cases sanctioning overtime to maintain service provision.
- Problems being consistent with therapeutic activity due to the turnover of staff and sickness.

10.3 Attached at Appendix 9 is a summary of the assurance and feedback received.

**Appendix 2**

## Budgeted and Actual Staffing Establishments

| Directorate | Service | Ward | Establishment at 1/6/14 | | | | Establishment at 31/5/15 | | | | Comparison 1/6/14 to 31/5/15 budget v actual hours | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | registered | | unregistered | | registered | | unregistered | | Registered | | Unregistered | |
| | | | Budget | Actual | Budget | Actual | Budget | Actual | Budget | Actual | Budget | Actual | Budget | Actual |
| D&D | MHSOP | Roseberry Wards | 8.58 | 8.92 | 11.44 | 11.33 | 8.58 | 8.32 | 11.44 | 11.36 | 0.00 | -0.60 | 0.00 | 0.03 |
| | | Ceddesfeld | 8.58 | 8.88 | 9.86 | 17.43 | 8.58 | 9.00 | 5.42 | 10.87 | 0.00 | 0.12 | -4.44 | -6.56 |
| | | Hamsterley | 8.58 | 11.00 | 9.86 | 10.64 | 8.58 | 8.80 | 7.00 | 9.60 | 0.00 | -2.20 | -2.86 | -1.04 |
| | | Oak Ward | 8.58 | 10.20 | 11.44 | 12.00 | 8.58 | 9.80 | 11.44 | 11.20 | 0.00 | -0.40 | 0.00 | -0.80 |
| | | Picktree | 8.58 | 10.86 | 9.86 | 10.81 | 8.58 | 9.44 | 8.82 | 8.44 | 0.00 | -1.42 | -1.04 | -2.37 |
| | CYPS | Holly | 4.64 | 4.60 | 7.96 | 6.40 | 4.76 | 4.60 | 5.22 | 5.60 | 0.12 | 0.00 | -2.74 | -0.80 |
| | LD | Bek,Talbot & Ramsey | 11.22 | 11.67 | 40.05 | 39.12 | 11.22 | 9.36 | 44.13 | 38.20 | 0.00 | -2.31 | 4.08 | -0.92 |
| | | Harland Rehab | | | | | 6.72 | 7.47 | 22.88 | 11.72 | 6.72 | 7.47 | 22.88 | 11.72 |
| | AMH | Tunstall | 8.58 | 8.60 | 11.44 | 12.80 | 8.85 | 8.00 | 11.44 | 12.80 | 0.27 | -0.60 | 0.00 | 0.00 |
| | | Farnham | 8.58 | 9.60 | 11.44 | 11.75 | 8.58 | 8.64 | 11.44 | 11.75 | 0.00 | -0.96 | 0.00 | 0.00 |
| | | Primrose Lodge | 8.58 | 8.43 | 11.44 | 9.53 | 8.58 | 8.60 | 11.44 | 10.13 | 0.00 | 0.17 | 0.00 | 0.60 |
| | | Elm | 8.58 | 7.70 | 11.44 | 11.40 | 8.58 | 8.70 | 11.44 | 10.40 | 0.00 | 1.00 | 0.00 | -1.00 |
| | | Cedar | 8.50 | 9.35 | 14.30 | 13.80 | 8.50 | 11.00 | 14.30 | 13.80 | 0.00 | 1.65 | 0.00 | 0.00 |
| | | Maple | 8.58 | 8.40 | 11.44 | 8.60 | 8.58 | 10.40 | 11.44 | 9.60 | 0.00 | 2.00 | 0.00 | 1.00 |
| | | Willow | 8.58 | 7.92 | 11.44 | 13.40 | 8.58 | 7.95 | 11.44 | 11.08 | 0.00 | 0.03 | 0.00 | -2.32 |
| | | Earlston House | 8.58 | 8.52 | 11.44 | 10.50 | 8.58 | 8.52 | 11.44 | 11.78 | 0.00 | 0.00 | 0.00 | 1.28 |
| | | Birch | 8.58 | 10.33 | 15.90 | 14.09 | 8.53 | 8.13 | 15.90 | 13.09 | -0.05 | -2.20 | 0.00 | -1.00 |
| NY | AMH | Ayckbourne Esk | 8.65 | 8.43 | 11.73 | 11.32 | 9.05 | 7.43 | 10.73 | 10.60 | 0.40 | -1.00 | -1.00 | -0.72 |
| | | Ayckbourne Danby | 8.65 | 8.00 | 11.73 | 11.00 | 9.05 | 7.00 | 10.73 | 10.00 | 0.40 | -1.00 | -1.00 | -1.00 |
| | | Ward 15 Friarage | 9.05 | 7.80 | 10.73 | 12.80 | 9.05 | 8.00 | 10.73 | 11.30 | 0.00 | 0.20 | 0.00 | -1.50 |
| | | Cedar Ward | 10.44 | 11.00 | 11.73 | 8.55 | 9.05 | 12.00 | 15.20 | 14.00 | -1.39 | 1.00 | 3.47 | 5.45 |
| | | Abdale House | 5.86 | 8.03 | 5.86 | 4.96 | 10.73 | 8.43 | 5.63 | 4.76 | 4.87 | 0.40 | -0.23 | -0.20 |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | MHSOP | Rowan Lea | 10.44 | 11.20 | 17.59 | 15.00 | 9.05 | 8.40 | 17.88 | 17.00 | -1.39 | -2.80 | 0.29 | 2.00 |
| | | Springwood | 10.44 | 9.40 | 11.73 | 10.60 | 9.05 | 9.60 | 12.51 | 11.60 | -1.39 | 0.20 | 0.78 | 1.00 |
| | | Ward 14 | 9.05 | 6.60 | 9.96 | 11.80 | 9.05 | 8.40 | 9.96 | 11.20 | 0.00 | 1.80 | 0.00 | -0.60 |
| | | Rowan Ward | 10.44 | 8.53 | 11.73 | 9.80 | 9.05 | 10.33 | 10.73 | 9.27 | -1.39 | 1.80 | -1.00 | -0.53 |
| | CYPS | Newberry Centre | 11.69 | 15.40 | 16.50 | 18.60 | 11.69 | 13.40 | 15.22 | 17.00 | 0.00 | -2.00 | -1.28 | -1.60 |
| | | Westwood Centre | 12.23 | 13.00 | 0.00 | 20.20 | 14.71 | 11.00 | 18.24 | 21.52 | 2.48 | -2.00 | 18.24 | 1.32 |
| | | Evergreen Centre | 11.72 | 10.60 | 15.30 | 15.40 | 10.83 | 10.80 | 16.03 | 15.50 | -0.89 | 0.20 | 0.73 | 0.10 |
| Forensic Services | LD | Clover / Ivy | 9.83 | 9.80 | 21.45 | 22.60 | 8.05 | 9.00 | 24.14 | 19.50 | -1.78 | -0.80 | 2.69 | -3.10 |
| | | Eagle/Osprey | 9.83 | 10.90 | 18.77 | 15.70 | 8.05 | 6.00 | 21.45 | 13.70 | -1.78 | -4.90 | 2.68 | -2.00 |
| | | Harrier Hawk | 9.83 | 8.00 | 21.45 | 14.80 | 8.05 | 5.90 | 24.14 | 19.60 | -1.78 | -2.10 | 2.69 | 4.80 |
| | | Kestrel /Kite | 9.83 | 12.90 | 21.45 | 18.00 | 8.05 | 10.80 | 24.14 | 19.70 | -1.78 | -2.10 | 2.69 | 1.70 |
| | | Kingfisher, Heron, Robin | 9.83 | 11.70 | 24.14 | 19.94 | 8.05 | 9.70 | 26.82 | 20.80 | -1.78 | -2.00 | 2.68 | 0.86 |
| | | Northdale Centre | 9.83 | 11.90 | 26.82 | 23.00 | 8.05 | 8.90 | 29.50 | 21.00 | -1.78 | -3.00 | 2.68 | -2.00 |
| | | Thistle | 8.05 | 7.00 | 13.41 | 11.00 | 8.05 | 7.00 | 13.41 | 13.00 | 0.00 | 0.00 | 0.00 | 2.00 |
| | | Activity Centre | 1.00 | 1.00 | 13.78 | 16.28 | 1.00 | 2.00 | 13.78 | 13.48 | 0.00 | 1.00 | 0.00 | -2.80 |
| | | Harland | 8.00 | 6.00 | 11.31 | 10.00 | | | | | -8.00 | -6.00 | -11.31 | -10.00 |
| | | Langley | 8.04 | 7.46 | 10.73 | 10.00 | 8.05 | 8.31 | 10.73 | 10.00 | 0.01 | 0.85 | 0.00 | 0.00 |
| | | Oakwood | 8.05 | 7.30 | 9.32 | 9.00 | 8.05 | 6.60 | 8.32 | 8.00 | 0.00 | -0.70 | -1.00 | -1.00 |
| | FMH | Jay | 8.05 | 7.50 | 13.41 | 13.00 | 8.05 | 6.80 | 13.41 | 13.00 | 0.00 | -0.70 | 0.00 | 0.00 |
| | | Fulmar | 8.05 | 6.50 | 16.10 | 15.60 | 8.05 | 7.60 | 15.32 | 15.20 | 0.00 | 1.10 | -0.78 | -0.40 |
| | | Nightingale | 8.05 | 7.80 | 13.41 | 14.80 | 8.05 | 6.90 | 13.15 | 13.70 | 0.00 | -0.90 | -0.26 | -1.10 |
| | | Merlin | 10.73 | 11.00 | 13.41 | 14.60 | 10.73 | 9.00 | 15.32 | 14.70 | 0.00 | -2.00 | 1.91 | 0.10 |
| | | Linnett | 8.05 | 6.50 | 13.40 | 12.95 | 8.05 | 8.50 | 13.15 | 13.20 | 0.00 | 2.00 | -0.25 | 0.25 |
| | | Teal | 8.05 | 0.00 | 13.40 | 0.00 | | | | | -8.05 | 0.00 | -13.40 | 0.00 |
| | | Newtondale | 10.73 | 7.80 | 18.77 | 16.60 | 10.73 | 9.90 | 17.88 | 17.50 | 0.00 | 2.10 | -0.89 | 0.90 |
| | | Brambling | 8.05 | 8.00 | 13.41 | 13.70 | 8.50 | 8.00 | 13.15 | 10.60 | 0.45 | 0.00 | -0.26 | -3.10 |
| | | Kirkdale | 8.05 | 7.90 | 16.09 | 15.80 | 8.05 | 7.90 | 15.32 | 15.11 | 0.00 | 0.00 | -0.77 | -0.69 |
| | | Mallard | 8.05 | 7.63 | 16.09 | 13.80 | 8.05 | 8.60 | 15.32 | 14.40 | 0.00 | 0.97 | -0.77 | 0.60 |
| | | Sandpiper | 10.72 | 10.00 | 17.88 | 17.40 | 10.73 | 8.00 | 17.11 | 17.50 | 0.01 | -2.00 | -0.77 | 0.10 |
| | | Mandarin | 8.05 | 7.00 | 13.40 | 13.00 | 8.05 | 7.00 | 13.15 | 12.90 | 0.00 | 0.00 | -0.25 | -0.10 |
| | | Lark | 8.05 | 8.00 | 13.41 | 13.60 | 8.05 | 8.00 | 13.15 | 14.00 | 0.00 | 0.00 | -0.26 | 0.40 |
| | | Swift | 8.05 | 8.00 | 16.09 | 16.03 | 8.05 | 6.43 | 15.32 | 14.93 | 0.00 | -1.57 | -0.77 | -1.10 |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Teesside | AMH | Lustrum Vale | 10.25 | 9.80 | 15.37 | 12.24 | 10.25 | 9.24 | 10.97 | 10.24 | 0.00 | -0.56 | -4.40 | -2.00 |
| | | Lincoln | 11.72 | 12.40 | 10.47 | 12.93 | 9.36 | 10.40 | 11.86 | 10.93 | -2.36 | -2.00 | 1.39 | -2.00 |
| | | Bilsdale | 9.72 | 8.80 | 12.36 | 10.20 | 8.22 | 6.80 | 10.97 | 12.00 | -1.50 | -2.00 | -1.39 | 1.80 |
| | | Overdale | 8.22 | 9.52 | 12.36 | 11.40 | 8.22 | 6.56 | 10.97 | 11.00 | 0.00 | -2.96 | -1.39 | -0.40 |
| | | Stockdale | 9.72 | 8.60 | 11.72 | 12.33 | 8.22 | 7.60 | 10.97 | 10.72 | -1.50 | -1.00 | -0.75 | -1.61 |
| | | Bransdale | 9.72 | 8.80 | 12.36 | 11.00 | 8.22 | 7.80 | 10.97 | 10.60 | -1.50 | -1.00 | -1.39 | -0.40 |
| | | Bedale | 9.72 | 9.80 | 14.67 | 12.40 | 8.22 | 8.00 | 13.71 | 10.40 | -1.50 | -1.80 | -0.96 | -2.00 |
| | | Park House | 7.83 | 9.80 | 10.97 | 10.00 | 7.83 | 7.60 | 10.97 | 10.01 | 0.00 | -2.20 | 0.00 | 0.01 |
| | CYPS | Baysdale | 9.66 | 8.68 | 13.63 | 12.93 | 6.66 | 7.08 | 12.74 | 11.71 | -3.00 | -1.60 | -0.89 | -1.22 |
| | MHSOP | Wingfield | 8.08 | 6.99 | 9.99 | 10.47 | 8.08 | 6.79 | 9.99 | 9.53 | 0.00 | -0.20 | 0.00 | -0.94 |
| | | Westerdale North | 8.10 | 9.10 | 13.96 | 12.77 | 8.22 | 8.19 | 10.97 | 10.76 | 0.12 | -0.91 | -2.99 | -2.01 |
| | | Westerdale South | 8.20 | 9.02 | 10.97 | 10.20 | 8.22 | 9.96 | 10.97 | 10.12 | 0.02 | 0.94 | 0.00 | -0.08 |
| | LD | Lodge | 2.00 | 5.60 | 2.00 | 9.80 | 1.00 | 0.00 | 0.00 | 0.00 | -1.00 | -5.60 | -2.00 | -9.80 |
| | | Bankfields 3&4 | 2.00 | 4.48 | 2.00 | 15.80 | 0.00 | 0.00 | 0.00 | 0.00 | -2.00 | -4.48 | -2.00 | -15.80 |
| | | Bankfields 2 | 6.84 | 8.80 | 9.45 | 8.72 | 6.84 | 8.00 | 9.45 | 7.97 | 0.00 | -0.80 | 0.00 | -0.75 |
| | | Bankfields Flats | 0.00 | 6.64 | 0.00 | 19.40 | | | | | 0.00 | -6.64 | 0.00 | -19.40 |
| | | Bankfields Qual | 2.00 | 0.00 | 1.00 | 0.00 | | | | | -2.00 | 0.00 | -1.00 | 0.00 |
| | | Bankfields unqual | 0.00 | 0.00 | 2.00 | 0.00 | | | | | 0.00 | 0.00 | -2.00 | 0.00 |
| | | Aysgarth | 5.50 | 6.53 | 7.00 | 8.19 | 5.96 | 5.40 | 11.48 | 9.29 | 0.46 | -1.13 | 4.48 | 1.10 |
| | | Thornaby Road | 3.40 | 3.60 | 10.32 | 9.03 | 3.40 | 3.60 | 10.32 | 9.69 | 0.00 | 0.00 | 0.00 | 0.66 |
| | | The Orchard | 2.30 | 2.00 | 3.00 | 2.93 | 2.30 | 3.00 | 3.00 | 4.00 | 0.00 | 1.00 | 0.00 | 1.07 |
| | | Kilton View | 2.65 | 3.00 | 11.49 | 9.65 | 2.65 | 3.00 | 11.50 | 10.39 | 0.00 | 0.00 | 0.01 | 0.74 |
| | | Bankfields F;ats 3&4 | 2.00 | 0.00 | 2.00 | 0.00 | | | | | -2.00 | 0.00 | -2.00 | 0.00 |
| | | The Dales | 10.85 | 12.60 | 25.40 | 21.88 | | | | | -10.85 | -12.60 | -25.40 | -21.88 |
| | | Bankfield Court | 14.30 | 18.92 | 57.31 | 48.04 | 14.30 | 18.92 | 57.31 | 48.04 | 0.00 | 0.00 | 0.00 | 0.00 |
| | | | **632.19** | **644.04** | **1028.04** | **1017.14** | **571.78** | **557.38** | **949.21** | **880.05** | **-60.41** | **-86.66** | **-78.83** | **-137.09** |

## MDT Budgeted Establishments

**Appendix 3**

| | | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | JAN-15 | FEB-15 | MAR-15 | Apr-15 | May-15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 431501 AMH D&D INPATIENT MANAGEMENT | B4 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B7 OCC THERAPY | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 |
| 431516 AMH IP NORTH DURHAM OCC THERAPY | B3 OCC THERAPY | 1.53 | 1.53 | 1.53 | 1.53 | 1.53 | 1.53 | 1.53 | 1.53 | 1.53 | 1.53 | 1.53 | 1.53 |
| | B4 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B5 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B6 OCC THERAPY | 1.21 | 1.21 | 1.21 | 1.21 | 1.21 | 1.21 | 1.21 | 1.21 | 1.21 | 1.21 | 1.21 | 1.21 |
| | B3 PHYSIOTHERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| 431532 AMH IP D&D PRIMROSE LODGE | B3 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B6 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| 431571 AMH N DURHAM MEDICAL INPATIENT | CONSULTANT | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 |
| | CLINICAL ASST | 0.09 | 0.09 | 0.09 | 0.09 | 0.09 | 0.09 | 0.09 | 0.09 | 0.09 | 0.09 | 0.09 | 0.09 |
| | B5 PHARMACY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| 431574 AMH D&D REHABILITATION | CONSULTANT | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B6 OCC THERAPY | 1.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | B8A PSYCHOLOGY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| 431614 AMH SD & DARLINGTON MEDICAL IP | CONSULTANT | 3.50 | 3.50 | 3.50 | 3.50 | 3.50 | 3.50 | 3.50 | 3.50 | 3.50 | 3.50 | 3.50 | 3.50 |
| | STAFF GRADE PRACT | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| 431622 AMP WP CEDAR WARD | CONSULTANT | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.00 | 0.00 |
| 431630 AMH WP WILLOW WARD | B3 OCC THERAPY | 1.00 | 1.00 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 |
| | B6 OCC THERAPY | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 |
| 431635 AMH IP D&D EARLSTON HOUSE | B3 OCC THERAPY | 0.00 | 0.00 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 |
| | B6 OCC THERAPY | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 |
| 431638 AMH DARLINGTON OCCUPATIONAL THERAPY | B3 OCC THERAPY | 2.40 | 2.40 | 2.40 | 2.40 | 2.40 | 2.40 | 2.40 | 2.40 | 2.40 | 2.40 | 2.40 | 2.40 |
| | B5 OCC THERAPY | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 |
| | B6 OCC THERAPY | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 |
| | B7 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| 431645 AMH IP WPH EATING DISORDERS | CONSULTANT | 0.70 | 0.70 | 0.70 | 0.70 | 0.70 | 0.70 | 0.70 | 0.70 | 0.70 | 0.70 | 0.70 | 0.70 |
| | B7 DIETICIAN | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B3 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B5 OCC THERAPY | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | B6 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B7 PHYSIOTHERAPY | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 |
| | B7 PSYCHOLOGY | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 1.60 |
| | B8A PSYCHOLOGY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 0.00 |
| 431679 AMH SD & D'TON PSYCHOLOGY INPAT | B4 PSYCHOLOGY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B8A PSYCHOLOGY | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 |
| | B8C PSYCHOLOGY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| 431689 AMH N DURHAM PSYCHOLOGY INPATS | B8B PSYCHOLOGY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| 431702 AMH TRUSTWIDE MOD VETERAN PROJ | B8C PSYCHOLOGY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| 431087 ALD LRH BEK WARD | B6 OCC THERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1.70 | 1.70 | 0.00 | 0.00 |
| | B6 PHYSIOTHERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1.70 | 1.70 |
| 431089 ALD LRH RAMSEY WARD | B5 OCC THERAPY | 0.12 | 0.12 | 0.12 | 0.12 | 0.12 | 0.12 | 0.12 | 0.12 | 0.12 | 0.12 | 0.12 | 0.12 |
| | B6 SPEECH THERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| 432106 MHSOP BOWES LYON ROSEBERRY W'D | B3 OCC THERAPY | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.33 | 0.33 | 0.33 | 0.33 | 0.33 | 0.33 |
| | B6 OCC THERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.83 | 0.41 |
| | B5 PHYSIOTHERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.25 |
| | B6 PHYSIOTHERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.58 |
| | B3 PAMS OTHER | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1.00 | 0.50 |
| 432107 MHSOP BOWES LYON PICKTREE W'D | B3 OCC THERAPY | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.33 | 0.33 | 0.33 | 0.33 | 0.33 | 0.33 |
| | B5 PHYSIOTHERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.50 | 0.25 |
| | B6 PHYSIOTHERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1.15 | 0.99 |
| | B3 PAMS OTHER | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.50 |
| 432156 MHSOP AP HAMSTERLEY CB | B3 OCC THERAPY | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 |
| | B6 OCC THERAPY | 0.00 | 0.00 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 |
| | B6 PHYSIOTHERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.58 |
| | B3 PAMS OTHER | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.40 |
| 432157 MHSOP AP CEDDESFELD CB | B3 OCC THERAPY | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 |
| | B6 OCC THERAPY | 0.00 | 0.00 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 |
| | B6 PHYSIOTHERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.25 |
| | B7 PHYSIOTHERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.30 |
| | B3 PAMS OTHER | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.40 |
| 432160 MHSOP AP HAMSTERLEY WARD | B3 OCC THERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 432161 MHSOP AP BINCHESTER WARD | B3 OCC THERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| 432168 MHSOP WP OAK WARDS | B3 OCC THERAPY | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.00 |
| | B6 OCC THERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.20 |
| | B6 PHYSIOTHERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.66 |
| | B3 PAMS OTHER | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.83 |
| 432650 AMH SWR AYCKBOURN UNIT | B2 OCC THERAPY | 1.00 | 0.22 | 0.22 | 0.22 | 0.22 | 0.22 | 0.22 | 0.00 | 0.00 | 0.00 | 0.22 | 0.22 |
| | B3 OCC THERAPY | 1.27 | 2.17 | 2.17 | 2.17 | 2.17 | 2.17 | 2.17 | 2.17 | 2.17 | 2.17 | 2.00 | 2.00 |
| | B5 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | B6 OCC THERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B3 PHYSIOTHERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1.00 | 1.00 |
| 436026 AMH IP HARROGATE REHAB RECOVER | B3 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B6 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B8A PSYCHOLOGY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | B8D PSYCHOLOGY | 0.00 | 0.00 | 0.00 | 0.40 | 0.40 | 0.40 | 0.40 | 0.40 | 0.40 | 0.40 | 0.00 | 0.00 |
| 436032 AMH IP FRIARAGE WARD 15 | B6 OCC THERAPY | 0.60 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | B8D PSYCHOLOGY | 0.51 | 0.51 | 0.51 | 0.51 | 0.51 | 0.51 | 0.51 | 0.51 | 0.51 | 0.51 | 0.51 | 0.51 |
| 436033 AMH IP HARROGATE BRIARY CEDAR | B3 OCC THERAPY | 0.43 | 0.43 | 0.43 | 0.43 | 0.43 | 0.43 | 0.43 | 0.43 | 0.43 | 0.43 | 0.43 | 0.43 |
| | B6 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 2.00 | 2.00 | 2.00 | 1.80 | 1.80 |
| | B8A PSYCHOLOGY | 0.00 | 0.00 | 0.00 | 0.50 | 0.50 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| 430100 CAMHS IP WLH NEWBERRY CENTRE | CONSULTANT | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 |
| | B5 DIETICIAN | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | B6 DIETICIAN | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 |
| | B5 PSYCHOLOGY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B8A PSYCHOLOGY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B8C PSYCHOLOGY | 0.25 | 0.25 | 0.25 | 0.25 | 0.25 | 0.25 | 0.25 | 0.25 | 0.25 | 0.25 | 0.25 | 0.25 |
| 430111 CAMHS IP WLH WESTWOOD CENTRE | CONSULTANT | 1.30 | 1.30 | 1.30 | 1.30 | 1.30 | 1.30 | 1.30 | 1.30 | 1.30 | 1.30 | 1.30 | 1.30 |
| | STAFF GRADE PRACT | 0.50 | 0.50 | 0.50 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 0.60 | 0.60 |
| | B5 DIETICIAN | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | B6 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B5 PSYCHOLOGY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.40 | 0.40 |
| | B8C PSYCHOLOGY | 0.54 | 0.54 | 0.54 | 0.54 | 0.54 | 0.54 | 0.54 | 0.54 | 0.54 | 0.54 | 0.54 | 0.54 |
| | SOCIAL WORKER - QUALIFIED | 0.37 | 0.37 | 0.37 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| 430121 CAMHS IP WLH EVERGREEN CENTRE | CONSULTANT | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 |
| | STAFF GRADE PRACT | 0.50 | 0.50 | 0.50 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B3 DIETICIAN | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | B6 DIETICIAN | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B6 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B7 PHYSIOTHERAPY | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 | 0.20 |
| | B8A PSYCHOLOGY | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 |
| | B8C PSYCHOLOGY | 0.40 | 0.40 | 0.40 | 0.40 | 0.40 | 0.40 | 0.40 | 0.40 | 0.40 | 0.40 | 0.40 | 0.40 |
| 432740 MHSOP IP SCARBOROUGH ROWAN LEA | B5 DIETICIAN | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.50 |
| | B6 DIETICIAN | 0.75 | 0.75 | 0.75 | 0.75 | 0.75 | 0.75 | 0.75 | 0.75 | 0.75 | 0.75 | 0.75 | 0.45 |
| | B2 OCC THERAPY | 1.20 | 1.20 | 1.20 | 1.20 | 1.20 | 1.20 | 1.20 | 1.20 | 1.20 | 1.20 | 1.20 | 1.20 |
| | B6 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B7 PHYSIOTHERAPY | 0.56 | 0.56 | 0.56 | 0.56 | 0.56 | 0.56 | 0.56 | 0.56 | 0.56 | 0.56 | 0.56 | 0.56 |
| 432742 MHSOP IP MALTON SPRINGWOOD | B5 DIETICIAN | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 |
| | B2 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B6 OCC THERAPY | 0.20 | 0.20 | 0.20 | 0.20 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 |
| | B6 SPEECH THERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 |
| | B7 SPEECH THERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.50 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | B8A PSYCHOLOGY | 0.51 | 0.51 | 0.51 | 0.51 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | B8C PSYCHOLOGY | 0.00 | 0.00 | 0.00 | 0.00 | 0.30 | 0.30 | 0.30 | 0.30 | 0.30 | 0.00 | 0.00 | 0.00 |
| 436058 MHSOP IP FRIARAGE WARD 14 | B6 DIETICIAN | 0.00 | 0.00 | 0.00 | 0.32 | 0.32 | 0.32 | 0.32 | 0.32 | 0.32 | 0.32 | 0.32 | 0.32 |
| | B6 OCC THERAPY | 0.59 | 0.59 | 0.59 | 0.59 | 0.59 | 0.59 | 0.59 | 0.59 | 0.59 | 0.59 | 0.59 | 0.59 |
| 436059 MHSOP IP HARROGATE ROWAN | B6 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B6 PHYSIOTHERAPY | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 |
| | B6 SPEECH THERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 |
| | B7 SPEECH THERAPY | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.50 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| 430014 AMH LUSTRUM VALE (24 HOUR NURSED CARE SERVICES) | B5 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| 430230 AMH IP SANDWELL PARK LINCOLN | B6 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B4 PAMS OTHER | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B8A PSYCHOLOGY | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 |
| 430546 AMH MIDDLESBROUGHOT IN PAT | B3 OCC THERAPY | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 |
| | B5 OCC THERAPY | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 | 3.00 |
| | B7 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| 430587 AMH RP MEDICAL PICU | CONSULTANT | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| 430728 AMH STH TEES OT CLINICAL LEAD | B7 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |

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| 430741 AMH IP MBORO PARK HOUSE | B8A PSYCHOLOGY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| 430743 AMH STH TEES OT REHAB | B8B OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| 430032 MHSOP NTH TEES MEDICAL INPATS | CONSULTANT | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 | 0.60 |
| | STAFF GRADE PRACT | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 |
| 430731 MHSOP RP WESTERDALE NORTH | B6 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B6 PHYSIOTHERAPY | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 |
| 430733 MHSOP RP WESTERDALE SOUTH | B5 OCC THERAPY | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| | B6 PHYSIOTHERAPY | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 |
| 430734 MHSOP STH TEES MEDICAL INPAT | CONSULTANT | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 |
| | STAFF GRADE PRACT | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 | 0.50 |
| | | **90.93** | **89.45** | **90.45** | **92.30** | **92.69** | **94.19** | **94.25** | **95.03** | **96.73** | **96.43** | **100.06** | **103.58** |

**Absence Factors and Additional Staffing Usage**

**Appendix 4**

| Ward Name | Locality | Speciality | Bed Numbers | Maternity | | Sickness | | Vacancies | | Total Bank Usage Vs Actual Hours | | Total Agency Usage Vs Actual Hours | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Hours | % loss against Actual Hours | Hours | % loss against Actual Hours | Hours | % loss against Actual Hours | Hours | % use against Actual Hours | Hours | % use against Actual Hours |
| Bek, Talbot and Ramsey | Durham & Darlington | LD | 16 | 237.00 | 0.3% | 6044.32 | 7.6% | 10627.50 | 13.4% | 8663.74 | 10.9% | 0.00 | 0.0% |
| Birch Ward | Durham & Darlington | ED | 15 | 1219.33 | 2.9% | 3678.90 | 8.7% | 1972.50 | 4.7% | 19920.60 | 47.2% | 1405.75 | 3.3% |
| Cedar | Durham & Darlington | AMH | 10 | 0.00 | 0.0% | 4192.35 | 7.9% | 2055.00 | 3.9% | 29489.05 | 55.4% | 476.25 | 0.9% |
| Earlston House | Durham & Darlington | AMH | 15 | 0.00 | 0.0% | 2409.00 | 7.4% | 348.75 | 1.1% | 2278.17 | 7.0% | 0.00 | 0.0% |
| Elm Ward | Durham & Darlington | AMH | 20 | 975.00 | 2.9% | 3480.58 | 10.2% | 1848.75 | 5.4% | 6918.64 | 20.3% | 0.00 | 0.0% |
| Farnham Ward | Durham & Darlington | AMH | 20 | 0.00 | 0.0% | 2436.00 | 7.3% | 487.50 | 1.5% | 3443.33 | 10.4% | 0.00 | 0.0% |
| Maple | Durham & Darlington | AMH | 17 | 0.00 | 0.0% | 3953.00 | 11.5% | 1353.75 | 3.9% | 8695.13 | 25.3% | 0.00 | 0.0% |
| Primrose Lodge | Durham & Darlington | AMH | 15 | 0.00 | 0.0% | 2472.50 | 7.7% | 1271.25 | 3.9% | 3914.00 | 12.1% | 0.00 | 0.0% |
| Tunstall Ward | Durham & Darlington | AMH | 20 | 0.00 | 0.0% | 1767.00 | 5.1% | 157.50 | 0.5% | 1308.84 | 3.8% | 0.00 | 0.0% |
| Willow Ward | Durham & Darlington | AMH | 15 | 0.00 | 0.0% | 4159.50 | 12.2% | 622.50 | 1.8% | 4124.50 | 12.1% | 0.00 | 0.0% |
| Ceddesfeld | Durham & Darlington | MHSOP | 15 | 0.00 | 0.0% | 3608.00 | 10.3% | 2505.00 | 7.1% | 2710.10 | 7.7% | 0.00 | 0.0% |
| Hamsterley | Durham & Darlington | MHSOP | 15 | 0.00 | 0.0% | 2916.50 | 8.6% | 2842.50 | 8.4% | 5529.64 | 16.3% | 0.00 | 0.0% |
| Oak Ward | Durham & Darlington | MHSOP | 12 | 0.00 | 0.0% | 2289.66 | 7.3% | 382.50 | 1.2% | 743.79 | 2.4% | 0.00 | 0.0% |
| Picktree | Durham & Darlington | MHSOP | 15 | 1387.50 | 3.9% | 1105.50 | 3.1% | 1305.00 | 3.6% | 9946.71 | 27.8% | 1014.50 | 2.8% |
| Roseberry Wards | Durham & Darlington | MHSOP | 15 | 637.50 | 2.0% | 2671.27 | 8.3% | 641.25 | 2.0% | 3674.92 | 11.4% | 0.00 | 0.0% |
| Holly | Durham & Darlington | CYPS | 4 | 570.00 | 3.3% | 1133.00 | 6.5% | 663.75 | 3.8% | 1039.46 | 6.0% | 0.00 | 0.0% |
| Clover / Ivy | Forensic Services | Forensic LD | 12 | 975.00 | 1.9% | 2616.08 | 5.1% | 3701.25 | 7.2% | 11771.78 | 23.0% | 0.00 | 0.0% |
| Eagle / Osprey | Forensic Services | Forensic LD | 10 | 637.50 | 1.4% | 5359.73 | 11.4% | 4158.75 | 8.8% | 18955.57 | 40.2% | 0.00 | 0.0% |
| Harrier / Hawk | Forensic Services | Forensic LD | 6 | 82.50 | 0.2% | 3409.75 | 8.7% | 3656.25 | 9.4% | 5944.85 | 15.2% | 0.00 | 0.0% |
| Kestrel / Kite | Forensic Services | Forensic LD | 16 | 1155.00 | 2.5% | 5314.08 | 11.5% | 5216.25 | 11.3% | 11044.98 | 24.0% | 0.00 | 0.0% |
| Kingfisher / Heron / Robin | Forensic Services | Forensic LD | 14 | 1522.50 | 3.0% | 3662.75 | 7.2% | 4005.00 | 7.8% | 12282.00 | 24.0% | 0.00 | 0.0% |
| Langley | Forensic Services | Forensic LD | 10 | 0.00 | 0.0% | 2729.00 | 9.5% | 701.25 | 2.4% | 3735.83 | 13.0% | 0.00 | 0.0% |
| Northdale Centre | Forensic Services | Forensic LD | 6 | 2580.00 | 4.3% | 6398.17 | 10.6% | 5193.75 | 8.6% | 25520.20 | 42.2% | 0.00 | 0.0% |
| Oakwood | Forensic Services | Forensic LD | 8 | 165.00 | 0.6% | 2907.00 | 11.1% | 633.75 | 2.4% | 1890.92 | 7.2% | 0.00 | 0.0% |
| Thistle Ward | Forensic Services | Forensic LD | 5 | 0.00 | 0.0% | 1583.00 | 4.5% | 2553.75 | 7.2% | 7643.64 | 21.6% | 0.00 | 0.0% |
| Brambling | Forensic Services | Forensic MH | 13 | 7855.65 | 20.4% | 2386.75 | 6.2% | 4230.00 | 11.0% | 17412.85 | 45.2% | 0.00 | 0.0% |
| Jay Ward | Forensic Services | Forensic MH | 5 | 0.00 | 0.0% | 1989.75 | 6.0% | 6611.25 | 20.0% | 5196.55 | 15.7% | 0.00 | 0.0% |
| Lark | Forensic Services | Forensic MH | 15 | 0.00 | 0.0% | 2257.00 | 6.6% | 4196.25 | 12.3% | 5596.75 | 16.4% | 0.00 | 0.0% |
| Linnet Ward | Forensic Services | Forensic MH | 17 | 1822.50 | 5.1% | 3049.56 | 8.6% | 4248.75 | 11.9% | 10636.75 | 29.8% | 0.00 | 0.0% |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mallard | Forensic Services | Forensic MH | 16 | 1721.25 | 3.5% | 1785.00 | 3.7% | 2403.75 | 4.9% | 23302.54 | 47.8% | 0.00 | 0.0% |
| Mandarin | Forensic Services | Forensic MH | 16 | 588.75 | 1.8% | 1759.25 | 5.3% | 5411.25 | 16.2% | 4600.15 | 13.7% | 0.00 | 0.0% |
| Merlin | Forensic Services | Forensic MH | 10 | 0.00 | 0.0% | 3155.08 | 7.0% | 4035.00 | 8.9% | 16598.34 | 36.6% | 0.00 | 0.0% |
| Newtondale | Forensic Services | Forensic MH | 20 | 2220.00 | 5.1% | 3383.50 | 7.8% | 3903.75 | 9.0% | 7644.00 | 17.6% | 0.00 | 0.0% |
| Nightingale | Forensic Services | Forensic MH | 16 | 825.00 | 2.4% | 971.25 | 2.8% | 4826.25 | 14.1% | 5816.00 | 17.0% | 0.00 | 0.0% |
| Sandpiper Ward | Forensic Services | Forensic MH | 8 | 1308.75 | 2.1% | 1562.25 | 2.5% | 3476.25 | 5.6% | 37746.47 | 61.3% | 0.00 | 0.0% |
| Swift Ward | Forensic Services | Forensic MH | 10 | 337.50 | 0.9% | 2218.91 | 5.7% | 2996.25 | 7.7% | 10048.83 | 25.9% | 0.00 | 0.0% |
| Kirkdale | Forensic Services | Locked Rehab | 16 | 1807.50 | 5.0% | 3848.33 | 10.6% | 5400.00 | 14.9% | 8156.25 | 22.5% | 0.00 | 0.0% |
| Fulmar Ward | Forensic Services | Locked Rehab | 12 | 532.50 | 1.3% | 1525.75 | 3.6% | 2100.00 | 5.0% | 14368.50 | 34.0% | 0.00 | 0.0% |
| Abdale House | North Yorkshire | AMH | 9 | 2355.00 | 12.3% | 2544.75 | 13.3% | 2298.75 | 12.1% | 1211.48 | 6.4% | 0.00 | 0.0% |
| Ayckbourn Danby Ward | North Yorkshire | AMH | 13 | 0.00 | 0.0% | 637.68 | 2.1% | 4428.75 | 14.5% | 5765.38 | 18.9% | 0.00 | 0.0% |
| Ayckbourn Esk Ward | North Yorkshire | AMH | 13 | 1005.00 | 3.3% | 1258.32 | 4.1% | 3420.00 | 11.2% | 7079.53 | 23.2% | 0.00 | 0.0% |
| Cedar (NY) | North Yorkshire | AMH | 18 | 3570.00 | 8.0% | 421.50 | 0.9% | 5205.00 | 11.6% | 10431.29 | 23.3% | 5156.80 | 11.5% |
| Ward 15 | North Yorkshire | AMH | 12 | 487.50 | 1.5% | 2562.50 | 7.8% | 4170.00 | 12.7% | 7135.68 | 21.8% | 0.00 | 0.0% |
| Rowan Lea | North Yorkshire | MHSOP | 20 | 0.00 | 0.0% | 2230.76 | 5.1% | 3930.00 | 9.0% | 1731.14 | 4.0% | 0.00 | 0.0% |
| Rowan Ward | North Yorkshire | MHSOP | 16 | 0.00 | 0.0% | 3467.50 | 9.7% | 3648.75 | 10.2% | 6341.40 | 17.7% | 1252.75 | 3.5% |
| Springwood | North Yorkshire | MHSOP | 14 | 0.00 | 0.0% | 4238.33 | 9.6% | 4447.50 | 10.1% | 5475.40 | 12.4% | 11791.97 | 26.8% |
| Ward 14 | North Yorkshire | MHSOP | 9 | 0.00 | 0.0% | 983.00 | 3.4% | 840.00 | 2.9% | 155.26 | 0.5% | 41.00 | 0.1% |
| Newberry Centre | North Yorkshire | CYPS | 14 | 2970.00 | 6.8% | 3534.84 | 8.1% | 1507.50 | 3.4% | 4622.83 | 10.6% | 0.00 | 0.0% |
| The Evergreen Centre | North Yorkshire | CYPS | 12 | 4515.00 | 9.9% | 1269.48 | 2.8% | 1627.50 | 3.6% | 11647.00 | 25.6% | 0.00 | 0.0% |
| Westwood Centre | North Yorkshire | CYPS | 12 | 1305.00 | 2.2% | 5260.13 | 8.7% | 6030.00 | 10.0% | 15668.88 | 25.9% | 0.00 | 0.0% |
| Aysgarth | Teesside | LD | 6 | 1550.00 | 5.6% | 963.00 | 3.5% | 1083.75 | 3.9% | 8970.60 | 32.3% | 0.00 | 0.0% |
| Bankfields Court, The Flatts | Teesside | LD | 6 | 2317.50 | 9.9% | 3847.21 | 16.4% | 0.00 | 0.0% | 7811.26 | 33.3% | 0.00 | 0.0% |
| Bankfields Court Unit 2 | Teesside | LD | 8 | 2356.00 | 8.6% | 2372.67 | 8.7% | 1158.75 | 4.2% | 8093.06 | 29.6% | 0.00 | 0.0% |
| Bankfields Court | Teesside | LD | 12 | 2745.00 | 4.7% | 3729.70 | 6.4% | 2838.75 | 4.9% | 12319.17 | 21.3% | 0.00 | 0.0% |
| The Dales | Teesside | LD | 7 | 3000.00 | 9.3% | 3923.00 | 12.1% | 6611.25 | 20.4% | 6102.25 | 18.8% | 0.00 | 0.0% |
| The Lodge | Teesside | LD | 1 | 1957.50 | 9.6% | 2149.00 | 10.5% | 787.50 | 3.9% | 1295.86 | 6.3% | 0.00 | 0.0% |
| Bedale Ward | Teesside | AMH | 10 | 0.00 | 0.0% | 3195.50 | 8.4% | 4590.00 | 12.1% | 12223.99 | 32.2% | 0.00 | 0.0% |
| Bilsdale | Teesside | AMH | 14 | 975.00 | 3.2% | 2356.00 | 7.7% | 3165.00 | 10.3% | 3858.25 | 12.6% | 0.00 | 0.0% |
| Bransdale | Teesside | AMH | 14 | 1350.00 | 4.4% | 3208.91 | 10.5% | 3101.25 | 10.1% | 7331.00 | 23.9% | 0.00 | 0.0% |
| Lincoln Ward | Teesside | AMH | 20 | 502.50 | 1.4% | 959.83 | 2.8% | 2700.00 | 7.8% | 5959.22 | 17.1% | 0.00 | 0.0% |
| Overdale | Teesside | AMH | 18 | 11.50 | 0.0% | 3568.50 | 11.1% | 2002.50 | 6.2% | 7305.70 | 22.8% | 0.00 | 0.0% |
| Park House | Teesside | AMH | 14 | 900.50 | 3.0% | 5140.83 | 17.4% | 0.00 | 0.0% | 11185.00 | 37.8% | 0.00 | 0.0% |
| Stockdale | Teesside | AMH | 18 | 187.50 | 0.6% | 3208.50 | 10.0% | 3686.25 | 11.5% | 8088.16 | 25.1% | 0.00 | 0.0% |
| Lustrum Vale | Teesside | MHSOP | 20 | 86.50 | 0.3% | 4397.50 | 13.0% | 2085.00 | 6.2% | 6584.50 | 19.5% | 0.00 | 0.0% |
| Westerdale North | Teesside | MHSOP | 18 | 11.50 | 0.0% | 1541.50 | 4.5% | 776.25 | 2.2% | 4137.75 | 12.0% | 0.00 | 0.0% |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Westerdale South | Teesside | MHSOP | 14 | 735.00 | 1.6% | 3451.16 | 7.6% | 536.25 | 1.2% | 23846.76 | 52.5% | 1497.05 | 3.3% |
| Wingfield | Teesside | MHSOP | 9 | 253.00 | 0.9% | 1038.00 | 3.7% | 2889.95 | 10.4% | 253.50 | 0.9% | 0.00 | 0.0% |
| Baysdale | Teesside | CYPS | 6 | 1087.50 | 3.8% | 2209.11 | 7.7% | 3082.50 | 10.7% | 2220.26 | 7.7% | 0.00 | 0.0% |

| | Green | Amber | Red |
|---|---|---|---|
| Maternity | 0-1.9% | 2-4.9% | 5% and over |
| Sickness | 0-1.9% | 2-5.9% | 5% and over |
| Vacancies | 0-4.9% | 5-9.9% | 10% and over |
| Bank Usage | 0-19.9% | 20-39.9% | 39.9% and over |
| Agency and Overtime | 0-2.9% | 3-3.9% | 4% and over |

## Occupied Bed Days – 12 Month Average

**Appendix 5**

| | | | | 12 Months - 1st June 2014 to 31st May 2015 | | | | | | Bank Usage Vs Actual Hours | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | RN Average % | | Unregistered Average % | | | |
| Known As | Locality | Specialty | Number of Beds | Occupied bed days | Bed Usage as a % | Day | Night | Day | Night | Hours | % against Actual Hours |
| Earlston House | Durham & Darlington | AMH | 15 | 5133 | 93.75 | 102.4% | 100.0% | 107.3% | 100.4% | 2278.17 | 7.02% |
| Primrose Lodge | Durham & Darlington | AMH | 15 | 4556 | 83.21 | 94.8% | 102.3% | 102.6% | 101.1% | 3914 | 12.15% |
| Birch Ward | Durham & Darlington | AMH | 15 | 5350 | 97.72 | 87.2% | 97.0% | 123.9% | 144.2% | 19920.6 | 47.17% |
| Farnham | Durham & Darlington | AMH | 20 | 6318 | 86.55 | 101.9% | 99.7% | 112.2% | 104.5% | 3443.33 | 10.37% |
| Tunstall | Durham & Darlington | AMH | 20 | 6596 | 90.36 | 100.8% | 99.9% | 126.8% | 104.2% | 1308.84 | 3.77% |
| Elm | Durham & Darlington | AMH | 20 | 7188 | 98.47 | 100.6% | 101.4% | 113.9% | 109.2% | 6918.64 | 20.25% |
| Maple | Durham & Darlington | AMH | 17 | 6197 | 99.87 | 94.9% | 101.7% | 112.9% | 118.4% | 8695.13 | 25.25% |
| Cedar | Durham & Darlington | AMH | 10 | 3054 | 83.67 | 73.7% | 88.8% | 134.4% | 123.9% | 29489.05 | 55.45% |
| Park House | Teesside | AMH | 14 | 4821 | 94.34 | 95.1% | 101.4% | 105.4% | 101.9% | 11185 | 37.76% |
| Lincoln Ward | Teesside | AMH | 20 | 5539 | 75.88 | 105.1% | 102.6% | 98.4% | 106.7% | 5959.22 | 17.15% |
| Lustrum Vale | Teesside | AMH | 20 | 6772 | 92.77 | 85.8% | 107.9% | 122.0% | 102.4% | 6584.5 | 19.47% |
| Bilsdale | Teesside | AMH | 14 | 5278 | 103.29 | 86.7% | 100.8% | 112.3% | 100.2% | 3858.25 | 12.55% |
| Bransdale | Teesside | AMH | 14 | 4682 | 91.62 | 93.0% | 100.8% | 105.6% | 101.1% | 7331 | 23.95% |
| Overdale | Teesside | AMH | 18 | 4746 | 72.24 | 81.0% | 97.8% | 112.7% | 102.5% | 7305.7 | 22.78% |
| Bedale | Teesside | AMH | 10 | 3027 | 82.93 | 84.2% | 101.9% | 136.0% | 111.3% | 12223.99 | 32.17% |
| Stockdale | Teesside | AMH | 18 | 6222 | 94.70 | 92.5% | 102.9% | 117.7% | 109.1% | 8088.16 | 25.14% |
| Ward 15 | North Yorkshire | AMH | 12 | 4478 | 102.24 | 75.1% | 104.5% | 121.7% | 99.0% | 7135.68 | 21.80% |
| Cedar (NY) | North Yorkshire | AMH | 18 | 5565 | 84.70 | 101.5% | 110.9% | 127.9% | 156.3% | 10431.29 | 23.28% |
| Danby Ward | North Yorkshire | AMH | 13 | 3814 | 80.38 | 108.8% | 91.1% | 93.1% | 90.1% | 5765.38 | 18.91% |
| Esk Ward | North Yorkshire | AMH | 13 | 4132 | 87.08 | 92.9% | 109.9% | 104.0% | 91.9% | 7079.53 | 23.18% |
| Baysdale | Teesside | CAMHS | 6 | 1338 | 61.10 | 110.0% | 100.0% | 98.3% | 99.5% | 2220.26 | 7.70% |
| Holly Unit | Durham & Darlington | CAMHS | 4 | 992 | 67.95 | 126.8% | 102.0% | 115.8% | 102.6% | 1039.46 | 5.98% |
| Evergreen Centre | North Yorkshire | CAMHS Tier 4 | 12 | 4164 | 95.07 | 92.4% | 102.4% | 123.7% | 113.4% | 11647 | 25.55% |
| Newverry Centre | North Yorkshire | CAMHS Tier 4 | 14 | 4037 | 79.00 | 94.7% | 106.0% | 102.9% | 106.3% | 4622.83 | 10.57% |
| Westwood Centre | North Yorkshire | CAMHS Tier 4 | 12 | 3664 | 83.65 | 102.2% | 109.6% | 122.4% | 116.7% | 15668.88 | 25.90% |
| Oakwood | Forensic Services | FLD | 8 | 2467 | 84.49 | 96.9% | 98.5% | 110.3% | 99.7% | 1890.92 | 7.21% |
| Langley | Forensic Services | FLD | 10 | 2962 | 81.15 | 78.6% | 101.0% | 101.4% | 100.8% | 3735.83 | 13.04% |
| Clover/Ivy | Forensic Services | FLD | 12 | 3473 | 79.29 | 103.4% | 106.9% | 94.2% | 106.6% | 11771.78 | 22.98% |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| Eagle/Osprey | Forensic Services | FLD | 10 | 3092 | 84.71 | 100.8% | 100.9% | 97.2% | 103.6% | 18955.57 | 40.22% |
| Harrier/Hawk | Forensic Services | FLD | 6 | 2311 | 105.53 | 77.1% | 106.3% | 82.7% | 92.4% | 5944.85 | 15.22% |
| Kingfisher/Heron/Robin | Forensic Services | FLD | 14 | 4818 | 94.29 | 94.8% | 105.8% | 98.2% | 95.5% | 12282 | 23.98% |
| Thistle | Forensic Services | FLD | 5 | 1757 | 96.27 | 81.7% | 107.1% | 109.2% | 116.2% | 7643.64 | 21.58% |
| Brambling | Forensic Services | FMH | 13 | 3859 | 81.33 | 92.8% | 101.3% | 114.1% | 135.3% | 17412.85 | 45.20% |
| Jay Ward | Forensic Services | FMH | 5 | 1298 | 71.12 | 78.0% | 100.2% | 104.4% | 100.1% | 5196.55 | 15.73% |
| Kirkdale | Forensic Services | FMH | 16 | 4500 | 77.05 | 89.4% | 102.4% | 97.3% | 99.2% | 8156.25 | 22.50% |
| Lark | Forensic Services | FMH | 15 | 5207 | 95.11 | 84.8% | 101.8% | 110.0% | 99.6% | 5596.75 | 16.40% |
| Linnet | Forensic Services | FMH | 17 | 6088 | 98.11 | 88.0% | 97.5% | 109.1% | 115.2% | 10636.75 | 29.83% |
| Mallard | Forensic Services | FMH | 16 | 5784 | 99.04 | 101.0% | 102.5% | 122.7% | 175.7% | 23302.54 | 47.82% |
| Mandarin | Forensic Services | FMH | 16 | 4997 | 85.57 | 87.8% | 104.3% | 99.7% | 98.1% | 4600.15 | 13.74% |
| Newtondale | Forensic Services | FMH | 20 | 6406 | 87.75 | 91.6% | 86.2% | 91.7% | 101.7% | 7644 | 17.64% |
| Nightingale | Forensic Services | FMH | 16 | 5132 | 87.88 | 85.0% | 100.9% | 108.1% | 102.8% | 5816 | 16.97% |
| Sandpiper | Forensic Services | FMH | 8 | 2434 | 83.36 | 93.9% | 85.1% | 131.6% | 222.5% | 37746.47 | 61.28% |
| Swift | Forensic Services | FMH | 10 | 3371 | 92.36 | 87.8% | 101.3% | 100.2% | 113.2% | 10048.83 | 25.92% |
| Fulmar | Forensic Services | FMH | 12 | 3705 | 84.59 | 89.5% | 103.3% | 112.8% | 133.5% | 14368.5 | 33.99% |
| Kestrel/Kite | Forensic Services | FMH | 16 | 5245 | 89.81 | 92.6% | 99.9% | 84.5% | 95.4% | 11044.98 | 23.96% |
| Merlin | Forensic Services | FMH | 10 | 2817 | 77.18 | 95.0% | 89.8% | 125.0% | 135.5% | 16598.34 | 36.57% |
| Bankfields Court | Teesside | LD | 12 | 2515 | 57.42 | 92.0% | 94.5% | 100.3% | 98.2% | 12319.17 | 21.29% |
| Bankfields Court, Unit 2 | Teesside | LD | 8 | 1773 | 60.72 | 128.7% | 101.1% | 104.2% | 106.2% | 8093.06 | 29.62% |
| Bankfields Court, The Flatts | Teesside | LD | 6 | 2077 | 94.84 | 94.9% | 88.5% | 88.7% | 94.6% | 7811.26 | 33.26% |
| The Lodge | Teesside | LD | 1 | 365 | 100.00 | 92.9% | 89.7% | 89.9% | 92.6% | 1295.86 | 6.35% |
| Aysgarth | Teesside | LD | 6 | 1617 | 73.84 | 112.9% | 100.0% | 141.0% | 101.4% | 8970.6 | 32.25% |
| The Dales | Teesside | LD | 7 | 453 | 17.73 | 54.4% | 91.9% | 57.4% | 68.0% | 6102.25 | 18.84% |
| Bek, Talbot & Ramsey | Durham & Darlington | LD | 16 | 3515 | 60.19 | 96.9% | 101.9% | 101.6% | 103.9% | 8663.74 | 10.93% |
| Ceddesfeld | Durham & Darlington | MHSOP | 15 | 3634 | 66.37 | 95.4% | 100.3% | 102.4% | 104.9% | 2710.1 | 7.70% |
| Hamsterley | Durham & Darlington | MHSOP | 15 | 3909 | 71.40 | 92.9% | 100.1% | 139.0% | 107.8% | 5529.64 | 16.34% |
| Picktree | Durham & Darlington | MHSOP | 15 | 4000 | 73.06 | 96.4% | 99.7% | 135.0% | 118.7% | 9946.71 | 27.81% |
| Robseberry | Durham & Darlington | MHSOP | 15 | 5131 | 93.72 | 95.0% | 92.3% | 100.5% | 100.1% | 3674.92 | 11.42% |
| Ward 14 | North Yorkshire | MHSOP | 9 | 3118 | 94.92 | 82.0% | 105.4% | 110.5% | 105.2% | 155.26 | 0.54% |
| Rowan | North Yorkshire | MHSOP | 16 | 4314 | 73.87 | 95.7% | 138.2% | 102.4% | 109.5% | 6341.4 | 17.71% |
| Springwood | North Yorkshire | MHSOP | 14 | 4637 | 90.74 | 58.6% | 99.5% | 197.7% | 135.7% | 5475.4 | 12.42% |
| Wingfield | Teesside | MHSOP | 9 | 3127 | 95.19 | 83.4% | 99.7% | 94.6% | 101.4% | 253.5 | 0.91% |
| Rowan Lea | North Yorkshire | MHSOP | 20 | 4877 | 66.81 | 97.3% | 110.0% | 97.6% | 94.1% | 1731.14 | 3.98% |
| Westerdale North | Teesside | MHSOP | 18 | 6575 | 100.08 | 101.3% | 101.4% | 126.2% | 113.4% | 4137.75 | 11.99% |
| Westerdale South | Teesside | MHSOP | 14 | 5145 | 100.68 | 101.6% | 101.1% | 200.0% | 175.9% | 23846.76 | 52.51% |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Oak Ward | Durham & Darlington | MHSOP | 12 | 4423 | 100.98 | 91.3% | 100.3% | 97.5% | 99.4% | 743.79 | 2.37% |
| Northdale | Forensic Services | FMH | 12 | 4101 | 93.63 | 99.1% | 105.8% | 98.3% | 107.8% | 25520.2 | 42.24% |
| | | **Total** | **495** | **281239** | **83.47** | | | | | | |

## Staffing Fill Rate – 12 Month Average

**Appendix 6**

| Known As | Locality | Speciality | Bed Numbers | 12 Months - 01/06/14 to 31/05/15 | | | | Bank Usage Vs Actual Hours | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | RN Average % | | Unregistered Average % | | | |
| | | | | Day | Night | Day | Night | Hours | % against Actual Hours |
| Birch Ward | Durham & Darlington | AMH | 15 | 87.2% | 97.0% | 123.9% | 144.2% | 19920.6 | 47.17% |
| Cedar | Durham & Darlington | AMH | 10 | 73.7% | 88.8% | 134.4% | 123.9% | 29489.05 | 55.45% |
| Earlston House | Durham & Darlington | AMH | 15 | 102.4% | 100.0% | 107.3% | 100.4% | 2278.17 | 7.02% |
| Elm Ward | Durham & Darlington | AMH | 20 | 100.6% | 101.4% | 113.9% | 109.2% | 6918.64 | 20.25% |
| Farnham Ward | Durham & Darlington | AMH | 20 | 101.9% | 99.7% | 112.2% | 104.5% | 3443.33 | 10.37% |
| Maple | Durham & Darlington | AMH | 17 | 94.9% | 101.7% | 112.9% | 118.4% | 8695.13 | 25.25% |
| Primrose Lodge | Durham & Darlington | AMH | 15 | 94.8% | 102.3% | 102.6% | 101.1% | 3914 | 12.15% |
| Tunstall Ward | Durham & Darlington | AMH | 20 | 100.8% | 99.9% | 126.8% | 104.2% | 1308.84 | 3.77% |
| Bedale Ward | Teesside | AMH | 10 | 84.2% | 101.9% | 136.0% | 111.3% | 12223.99 | 32.17% |
| Bilsdale | Teesside | AMH | 14 | 86.7% | 100.8% | 112.3% | 100.2% | 3858.25 | 12.55% |
| Bransdale | Teesside | AMH | 14 | 93.0% | 100.8% | 105.6% | 101.1% | 7331 | 23.95% |
| Lincoln Ward | Teesside | AMH | 20 | 105.1% | 102.6% | 98.4% | 106.7% | 5959.22 | 17.15% |
| Overdale | Teesside | AMH | 18 | 81.0% | 97.8% | 112.7% | 102.5% | 7305.7 | 22.78% |
| Park House | Teesside | AMH | 14 | 95.1% | 101.4% | 105.4% | 101.9% | 11185 | 37.76% |
| Stockdale | Teesside | AMH | 18 | 92.5% | 102.9% | 117.7% | 109.1% | 8088.16 | 25.14% |
| Lustrum Vale | Teesside | AMH | 20 | 85.8% | 107.9% | 122.0% | 102.4% | 6584.5 | 19.47% |
| Abdale House | North Yorkshire | AMH | 9 | 102.1% | 100.1% | 72.7% | 91.8% | 1211.48 | 6.35% |
| Ayckbourn Danby Ward | North Yorkshire | AMH | 13 | 108.8% | 91.1% | 93.1% | 90.1% | 5765.38 | 18.91% |
| Ayckbourn Esk Ward | North Yorkshire | AMH | 13 | 92.9% | 109.9% | 104.0% | 91.9% | 7079.53 | 23.18% |
| Cedar (NY) | North Yorkshire | AMH | 18 | 101.5% | 110.9% | 127.9% | 156.3% | 10431.29 | 23.28% |
| Ward 15 | North Yorkshire | AMH | 12 | 75.1% | 104.5% | 121.7% | 99.0% | 7135.68 | 21.80% |
| Holly | Durham & Darlington | CAMHS | 4 | 126.8% | 102.0% | 115.8% | 102.6% | 1039.46 | 5.98% |
| Baysdale | Teesside | CAMHS | 6 | 110.0% | 100.0% | 98.3% | 99.5% | 2220.26 | 7.70% |
| Newberry Centre | North Yorkshire | CAMHS Tier 4 | 14 | 94.7% | 106.0% | 102.9% | 106.3% | 4622.83 | 10.57% |
| The Evergreen Centre | North Yorkshire | CAMHS Tier 4 | 12 | 92.4% | 102.4% | 123.7% | 113.4% | 11647 | 25.55% |
| Westwood Centre | North Yorkshire | CAMHS Tier 4 | 12 | 102.2% | 109.6% | 122.4% | 116.7% | 15668.88 | 25.90% |
| Clover / Ivy | Forensic Services | FLD | 12 | 103.4% | 106.9% | 94.2% | 106.6% | 11771.78 | 22.98% |
| Eagle / Osprey | Forensic Services | FLD | 10 | 100.8% | 100.9% | 97.2% | 103.6% | 18955.57 | 40.22% |
| Harland | Forensic Services | FLD | 0 | 84.2% | 100.0% | 108.1% | 200.0% | 551.75 | 22.58% |
| Harrier / Hawk | Forensic Services | FLD | 6 | 77.1% | 106.3% | 82.7% | 92.4% | 5944.85 | 15.22% |
| Kestrel / Kite | Forensic Services | FLD | 16 | 92.6% | 99.9% | 84.5% | 95.4% | 11044.98 | 23.96% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Kingfisher / Heron / Robin | Forensic Services | FLD | 14 | 94.8% | 105.8% | 98.2% | 95.5% | 12282 | 23.98% |
| Langley | Forensic Services | FLD | 10 | 78.6% | 101.0% | 101.4% | 100.8% | 3735.83 | 13.04% |
| Oakwood | Forensic Services | FLD | 8 | 96.9% | 98.5% | 110.3% | 99.7% | 1890.92 | 7.21% |
| Thistle Ward | Forensic Services | FLD | 5 | 81.7% | 107.1% | 109.2% | 116.2% | 7643.64 | 21.58% |
| Brambling | Forensic Services | FMH | 13 | 92.8% | 101.3% | 114.1% | 135.3% | 17412.85 | 45.20% |
| Fulmar Ward | Forensic Services | FMH | 12 | 89.5% | 103.3% | 112.8% | 133.5% | 14368.5 | 33.99% |
| Jay Ward | Forensic Services | FMH | 5 | 78.0% | 100.2% | 104.4% | 100.1% | 5196.55 | 15.73% |
| Kirkdale | Forensic Services | FMH | 16 | 89.4% | 102.4% | 97.3% | 99.2% | 8156.25 | 22.50% |
| Lark | Forensic Services | FMH | 15 | 84.8% | 101.8% | 110.0% | 99.6% | 5596.75 | 16.40% |
| Linnet Ward | Forensic Services | FMH | 17 | 88.0% | 97.5% | 109.1% | 115.2% | 10636.75 | 29.83% |
| Mallard | Forensic Services | FMH | 16 | 101.0% | 102.5% | 122.7% | 175.7% | 23302.54 | 47.82% |
| Mandarin | Forensic Services | FMH | 16 | 87.8% | 104.3% | 99.7% | 98.1% | 4600.15 | 13.74% |
| Merlin | Forensic Services | FMH | 10 | 95.0% | 89.8% | 125.0% | 135.5% | 16598.34 | 36.57% |
| Newtondale | Forensic Services | FMH | 20 | 91.6% | 86.2% | 91.7% | 101.7% | 7644 | 17.64% |
| Nightingale | Forensic Services | FMH | 16 | 85.0% | 100.9% | 108.1% | 102.8% | 5816 | 16.97% |
| Northdale Centre | Forensic Services | FMH | 6 | 99.1% | 105.8% | 98.3% | 107.8% | 25520.2 | 42.24% |
| Sandpiper Ward | Forensic Services | FMH | 8 | 93.9% | 85.1% | 131.6% | 222.5% | 37746.47 | 61.28% |
| Swift Ward | Forensic Services | FMH | 10 | 87.8% | 101.3% | 100.2% | 113.2% | 10048.83 | 25.92% |
| Bek, Talbot and Ramsey | Durham & Darlington | LD | 16 | 96.9% | 101.9% | 101.6% | 103.9% | 8663.74 | 10.93% |
| Aysgarth | Teesside | LD | 6 | 112.9% | 100.0% | 141.0% | 101.4% | 8970.6 | 32.25% |
| Bankfields Court, The Flatts | Teesside | LD | 6 | 94.9% | 88.5% | 88.7% | 94.6% | 7811.26 | 33.26% |
| Bankfields Court Unit 2 | Teesside | LD | 8 | 128.7% | 101.1% | 104.2% | 106.2% | 8093.06 | 29.62% |
| Bankfields Court | Teesside | LD | 12 | 92.0% | 94.5% | 100.3% | 98.2% | 12319.17 | 21.29% |
| The Dales | Teesside | LD | | 54.4% | 91.9% | 57.4% | 68.0% | 6102.25 | 18.84% |
| The Lodge | Teesside | LD | | 92.9% | 89.7% | 89.9% | 92.6% | 1295.86 | 6.35% |
| Ceddesfeld | Durham & Darlington | MHSOP | 15 | 95.4% | 100.3% | 102.4% | 104.9% | 2710.1 | 7.70% |
| Hamsterley | Durham & Darlington | MHSOP | 15 | 92.9% | 100.1% | 139.0% | 107.8% | 5529.64 | 16.34% |
| Oak Ward | Durham & Darlington | MHSOP | 12 | 91.3% | 100.3% | 97.5% | 99.4% | 743.79 | 2.37% |
| Picktree | Durham & Darlington | MHSOP | 15 | 96.4% | 99.7% | 135.0% | 118.7% | 9946.71 | 27.81% |
| Roseberry Wards | Durham & Darlington | MHSOP | 15 | 95.0% | 92.3% | 100.5% | 100.1% | 3674.92 | 11.42% |
| Westerdale North | Teesside | MHSOP | 18 | 101.3% | 101.4% | 126.2% | 113.4% | 4137.75 | 11.99% |
| Westerdale South | Teesside | MHSOP | 14 | 101.6% | 101.1% | 200.0% | 175.9% | 23846.76 | 52.51% |
| Wingfield | Teesside | MHSOP | 9 | 83.4% | 99.7% | 94.6% | 101.4% | 253.5 | 0.91% |
| Rowan Lea | North Yorkshire | MHSOP | 20 | 97.3% | 110.0% | 97.6% | 94.1% | 1731.14 | 3.98% |
| Rowan Ward | North Yorkshire | MHSOP | 16 | 95.7% | 138.2% | 102.4% | 109.5% | 6341.4 | 17.71% |
| Springwood | North Yorkshire | MHSOP | 14 | 58.6% | 99.5% | 197.7% | 135.7% | 5475.4 | 12.42% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Ward 14 | North Yorkshire | MHSOP | 9 | 82.0% | 105.4% | 110.5% | 105.2% | 155.26 | 0.54% |

## Quality Indicators

**Appendix 7**

| Scored Fill Rate compared to Quality Indicators | | | | Bank Usage V's Actual Hours (12 Month Average) | | 12 Month Totals for Quality Indicators | | | | | Incidents of Restraint - 12 Month Total | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Known As | Loclaity | Speciality | Bed Numbers | Hours | % Against Actual Hours | SUI | Level 4 Incidents | Level 3 (Self-Harm) Incidents | Complaints | PALS | Incidents | PRO used | Other | Restraint Total |
| Tunstall Ward | Durham & Darlington | AMH | 20 | 1308.84 | 3.77% | 1 | 1 | 5 | 1 | 11 | 12 | 4 | 18 | 22 |
| Earlston House | Durham & Darlington | AMH | 15 | 2278.17 | 7.02% | | | | | 2 | 2 | 1 | 5 | 6 |
| Farnham Ward | Durham & Darlington | AMH | 20 | 3443.33 | 10.37% | 2 | | 3 | 2 | 7 | 9 | 3 | 11 | 14 |
| Elm Ward | Durham & Darlington | AMH | 20 | 6918.64 | 20.25% | | | 10 | 2 | 15 | 39 | 12 | 52 | 64 |
| Birch Ward | Durham & Darlington | AMH | 15 | 19920.6 | 47.17% | 1 | | 5 | 2 | 2 | 14 | 1 | 20 | 21 |
| Maple Ward | Durham & Darlington | AMH | 17 | 8695.13 | 25.25% | 1 | 1 | 5 | 5 | 18 | 21 | 4 | 27 | 31 |
| Primrose Lodge | Durham & Darlington | AMH | 15 | 3914 | 12.15% | | 2 | 6 | | 1 | 6 | 0 | 9 | 9 |
| Willow Ward | Durham & Darlington | AMH | 15 | 4124.50 | 12.1% | | | | 1 | 15 | 23 | 4 | 39 | 43 |
| Cedar Ward | Durham & Darlington | AMH | 10 | 29489.05 | 55.45% | | | 8 | 2 | 10 | 85 | 50 | 135 | 185 |
| Lincoln Ward | Teesside | AMH | 20 | 5959.22 | 17.15% | | 1 | 2 | | 2 | 12 | 0 | 15 | 15 |
| Stockdale Ward | Teesside | AMH | 18 | 8088.16 | 25.14% | | 2 | 1 | 2 | 8 | 16 | 4 | 24 | 28 |
| Bransdale Ward | Teesside | AMH | 14 | 7331 | 23.95% | | 2 | 6 | 1 | 5 | 33 | 1 | 52 | 53 |
| Lustrum Vale | Teesside | AMH | 20 | 6584.5 | 19.47% | | | | 1 | 3 | 9 | 0 | 13 | 13 |
| Bilsdale Ward | Teesside | AMH | 14 | 3858.25 | 12.55% | 1 | 2 | 4 | 3 | 14 | 11 | 2 | 13 | 15 |
| Bedale Ward | Teesside | AMH | 10 | 12223.99 | 32.17% | | | | 1 | 3 | 140 | 20 | 182 | 202 |
| Park House | Teesside | AMH | 14 | 11185 | 37.76% | | | | 1 | 3 | 3 | 0 | 3 | 3 |
| Overdale Ward | Teesside | AMH | 18 | 7305.7 | 22.78% | | | 2 | 2 | 7 | 36 | 0 | 57 | 57 |

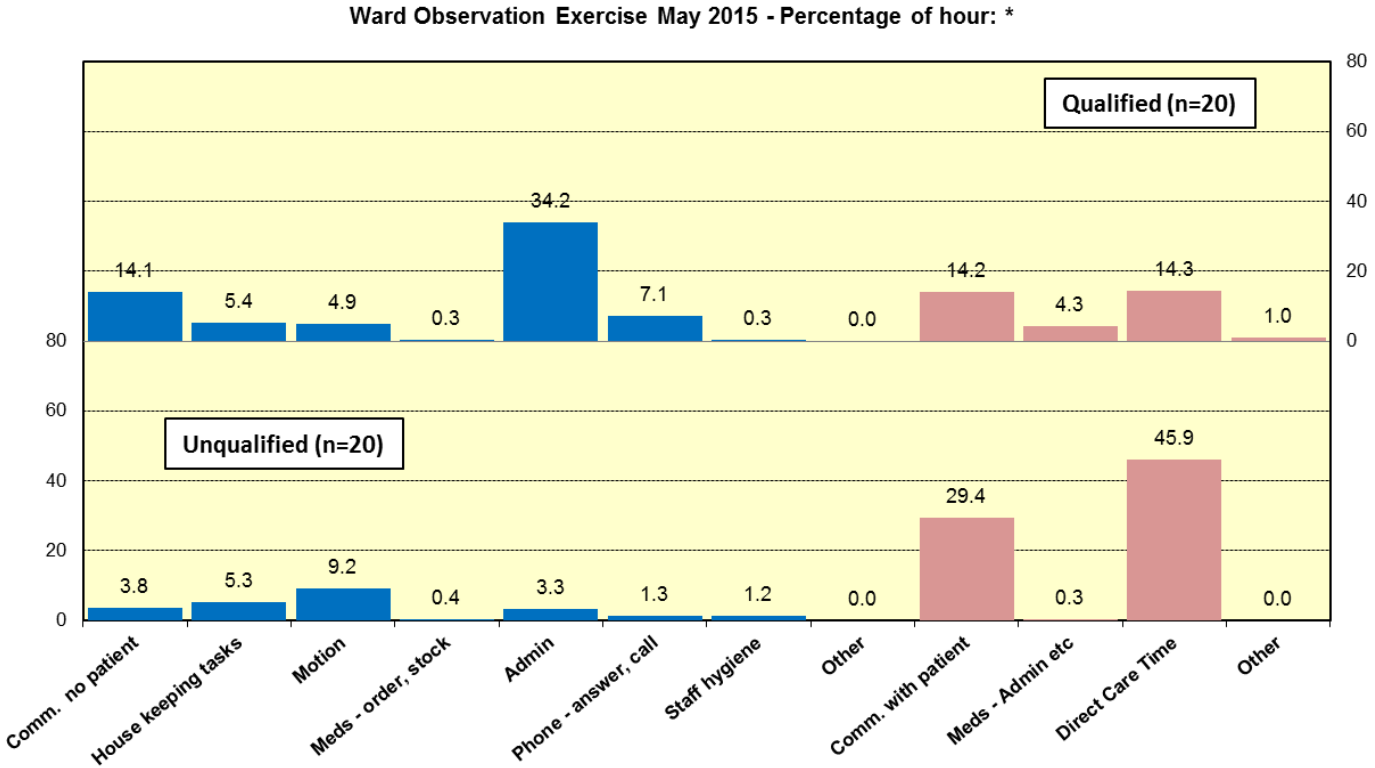
| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cedar Ward (NY) | North Yorkshire | AMH | 18 | 10431.29 | 23.28% | | 1 | 15 | 5 | 9 | 66 | 26 | 113 | 139 |
| Ward 15 Friarage | North Yorkshire | AMH | 12 | 7135.68 | 21.80% | | | 1 | 3 | 5 | 30 | 7 | 51 | 58 |
| Ayckbourn Unit Esk Ward | North Yorkshire | AMH | 13 | 7079.53 | 23.18% | 1 | 1 | 3 | 5 | | 67 | 18 | 96 | 114 |
| Ayckbourn Unit Danby Ward | North Yorkshire | AMH | 13 | 5765.38 | 18.91% | | 1 | | | 13 | | | | |
| Abdale House | North Yorkshire | AMH | 9 | 1211.48 | 6.35% | | | | | | | | | |
| Holly Unit | Durham & Darlington | CAMHS | 4 | 1039.46 | 5.98% | | | | | 1 | 1 | 0 | 2 | 2 |
| Baysdale | Teesside | CAMHS | 6 | 2220.26 | 7.70% | | | | | 2 | 2 | 0 | 2 | 2 |
| Westwood Centre | North Yorkshire | CAMHS Tier 4 | 12 | 15668.88 | 25.90% | | 1 | 5 | 1 | 1 | 693 | 181 | 1242 | 1423 |
| Newberry Centre | North Yorkshire | CAMHS Tier 4 | 14 | 4622.83 | 10.57% | | 1 | 6 | 3 | 7 | 312 | 46 | 485 | 531 |
| The Evergreen Centre | North Yorkshire | CAMHS Tier 4 | 12 | 11647 | 25.55% | | | 11 | | 2 | 339 | 24 | 607 | 631 |
| Langley Ward | Forensic Services | FLD | 10 | 3735.83 | 13.04% | | | | | | | | | |
| Eagle/Osprey | Forensic Services | FLD | 10 | 18955.57 | 40.22% | | | | 1 | 4 | 3 | 0 | 4 | 4 |
| Oakwood | Forensic Services | FLD | 8 | 1890.92 | 7.21% | | | | | | | | | |
| Kingfisher/Heron/Robin | Forensic Services | FLD | 14 | 12282 | 23.98% | | | | 2 | 21 | 5 | 0 | 9 | 9 |
| Thistle Ward | Forensic Services | FLD | 5 | 7643.64 | 21.58% | | | | 1 | 16 | 179 | 36 | 337 | 373 |
| Clover/Ivy | Forensic Services | FLD | 12 | 11771.78 | 22.98% | | 2 | 10 | | 13 | 20 | 9 | 41 | 50 |
| Kestrel/Kite | Forensic Services | FLD | 16 | 11044.98 | 23.96% | | | | | 3 | 3 | 1 | 3 | 4 |
| Harrier/Hawk | Forensic Services | FLD | 6 | 5944.85 | 15.22% | | 1 | | 3 | 17 | 23 | 2 | 27 | 29 |
| Harland | Forensic Services | FLD | | | | | | | | | | | | |
| Mallard Ward | Forensic Services | FMH | 16 | 23302.54 | 47.82% | 1 | 1 | | 2 | | 145 | 0 | 172 | 172 |
| Northdale Centre | Forensic Services | FMH | 6 | 25520.2 | 42.24% | | 2 | 2 | 2 | 21 | 54 | 16 | 80 | 96 |
| Brambling Ward | Forensic Services | FMH | 13 | 17412.85 | 45.20% | | | 7 | 2 | 4 | 67 | 14 | 101 | 115 |
| Merlin | Forensic Services | FMH | 10 | 16598.34 | 36.57% | | | | 2 | 7 | 42 | 16 | 92 | 108 |
| Fulmar Ward. | Forensic Services | FMH | 12 | 14368.5 | 33.99% | | 1 | 21 | 2 | 5 | 255 | 74 | 439 | 513 |
| Jay Ward | Forensic Services | FMH | 5 | 5196.55 | 15.73% | | 2 | | | 4 | 16 | 6 | 21 | 27 |
| Nightingale Ward | Forensic Services | FMH | 16 | 5816 | 16.97% | | 1 | | | 3 | 2 | 0 | 4 | 4 |
| Sandpiper Ward | Forensic Services | FMH | 8 | 37746.47 | 61.28% | | 2 | 3 | 1 | 7 | 149 | 27 | 315 | 342 |
| Linnet Ward | Forensic Services | FMH | 17 | 10636.75 | 29.83% | | | | | 6 | 6 | 0 | 7 | 7 |
| Swift Ward | Forensic Services | FMH | 10 | 10048.83 | 25.92% | | 1 | 6 | | 5 | 177 | 28 | 284 | 312 |
| Kirkdale Ward | Forensic Services | FMH | 16 | 8156.25 | 22.50% | | 6 | | 2 | 12 | 13 | 2 | 20 | 22 |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Lark | Forensic Services | FMH | 15 | 5596.75 | 16.40% | | | | 1 | 4 | 1 | 0 | 1 | 1 |
| Mandarin | Forensic Services | FMH | 16 | 4600.15 | 13.74% | | 3 | 1 | 2 | 40 | 18 | 4 | 19 | 23 |
| Newtondale Ward | Forensic Services | FMH | 20 | 7644 | 17.64% | 1 | 2 | | 2 | 2 | 9 | 1 | 14 | 15 |
| Aysgarth | Teesside | LD | 6 | 8970.6 | 32.25% | | | | | | 8 | 0 | 10 | 10 |
| Bankfields Court Unit 2 | Teesside | LD | 8 | 8093.06 | 29.62% | | | | 1 | 1 | 7 | 0 | 9 | 9 |
| Bankfields Court Unit 3 & 4 | Teesside | LD | 12 | 12319.17 | 21.29% | | | 11 | | 1 | 301 | 18 | 392 | 410 |
| Bankfields Court Flats | Teesside | LD | 6 | 7811.26 | 33.26% | | | 1 | | | 30 | 1 | 42 | 43 |
| The Lodge | Teesside | LD | 1 | 1295.86 | 6.35% | | | 1 | | | 24 | 1 | 46 | 47 |
| The Dales | Teesside | LD | 7 | 6102.25 | 18.84% | | | | | 1 | 11 | 0 | 11 | 11 |
| Bek, Ramsey, Talbot Wards | Durham & Darlington | LD | 16 | 8663.74 | 10.93% | | | | 2 | 4 | 71 | 16 | 91 | 107 |
| Westerdale South | Teesside | MHSOP | 14 | 23846.76 | 52.51% | | 1 | | 1 | 2 | 31 | 0 | 48 | 48 |
| Westerdale North | Teesside | MHSOP | 18 | 4137.75 | 11.99% | | 1 | 1 | 3 | 9 | 17 | 0 | 23 | 23 |
| Wingfield Ward | Teesside | MHSOP | 9 | 253.5 | 0.91% | 1 | | | 1 | 1 | 6 | 2 | 8 | 10 |
| Hamsterley Ward | Durham & Darlington | MHSOP | 12 | 5529.64 | 16.34% | | | | | | 74 | 0 | 88 | 88 |
| Ceddesfeld Ward | Durham & Darlington | MHSOP | 10 | 2710.1 | 7.70% | | | | | 1 | 74 | 1 | 120 | 121 |
| Picktree Ward. | Durham & Darlington | MHSOP | 10 | 9946.71 | 27.81% | | 1 | | 1 | 1 | 22 | 0 | 26 | 26 |
| Oak Ward | Durham & Darlington | MHSOP | 12 | 743.79 | 2.37% | 1 | 1 | 1 | | | 6 | 0 | 7 | 7 |
| Roseberry Wards | Durham & Darlington | MHSOP | 15 | 3674.92 | 11.42% | | 1 | | 1 | | 10 | 0 | 14 | 14 |
| Rowan Ward | North Yorkshire | MHSOP | 16 | 6341.4 | 17.71% | | 2 | 1 | 2 | 4 | 60 | 3 | 88 | 91 |
| Ward 14 | North Yorkshire | MHSOP | 9 | 155.26 | 0.54% | | 1 | | 1 | 1 | 51 | 0 | 70 | 70 |
| Springwood Community Unit | North Yorkshire | MHSOP | 14 | 5475.4 | 12.42% | | 2 | | | 5 | 108 | 0 | 124 | 124 |
| Rowan Lea | North Yorkshire | MHSOP | 20 | 1731.14 | 3.98% | | 1 | 1 | | 7 | 84 | 0 | 119 | 119 |
| **TOTAL** | | | | | | **11** | **51** | **165** | **81** | **398** | **4163** | **686** | **6599** | **7285** |

## Contact Time - All Staff – May 2015

**Appendix 8**

| | | Ward Observation Exercise May 2015 - Percentage of hour: * | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Non Direct Care | | | | | | | | Direct Care | | | |
| | | Comm. no patient | House keeping tasks | Motion | Meds - order, stock | Admin | Phone - answer, call | Staff hygiene | Other | Comm. with patient | Meds - Admin etc | Direct Care Time | Other |
| * | Qualified | 14.1 | 5.4 | 4.9 | 0.3 | 34.2 | 7.1 | 0.3 | 0.0 | 14.2 | 4.3 | 14.3 | 1.0 |
| * | Unqualified | 3.8 | 5.3 | 9.2 | 0.4 | 3.3 | 1.3 | 1.2 | 0.0 | 29.4 | 0.3 | 45.9 | 0.0 |
| * | Qualified | 66.2 | | | | | | | | 33.8 | | | |
| * | Unqualified | 24.4 | | | | | | | | 75.6 | | | |



## Hard Truths Compliance and Censes

## Appendix 9

| Contact and Job Title | Patch covered | Confirmation that you are recording within your wards the daily staffing report and identification of named nurse and doctor near the bed of each individual patient | Could you answer “are there the resources to safely manage the ward and provide required therapeutic activities?” |
|---|---|---|---|
| Alastair Jeeves Service Manager | Bankfields Court | Yes | Yes |
| Lee Bradley Modern Matron | Merlin, Mandarin, Linnet, Nightingale and Jay wards in FMH | I can confirm that all of these areas display the days staffing levels (budgeted and actual), and also have the named nurse and consultant on a notice by the bedroom doors | We also have the resources to manage all of these areas |
| Michelle Parkes Modern Matron | Sandpiper, Swift and Brambling | These wards also have staffing numbers displayed in the day area and named nurse consultant notices at each bedroom. | We have the resource to manage these areas based on budget. Unfortunately there are some occasions when we do not in my opinion. But this is on a rare occasion of exceptionally high clinical acuity when central bank has been unable to fulfil our requests and overtime has not been taken up. |
| Alison McIntyre Modern Matron | Teesside AMH | Yes we complete the hard truths board which is located out on the main foyer every day. We also ensure that the named nurse and doctor is in each bedroom | Yes the staffing resources are appropriate and we have a dedicated activity suite service which supports with therapeutic activities |
| Sharon Salvin Ward Manager | Lincoln Ward | Continue to update the daily staffing board and have the signs in the patient rooms with the details of consultant and named nurse | We have also been safely staffed in the last month. At times I (ward manager) have had to cover the ward as second qualified but this has not compromised safety and have had enough staff to carry out activities, leaves etc. |
| Tanya Turnbull Ward Manager | Tunstall and Farnham | Both wards have Hard Truth Boards with the ratio of staff and skill mix, we also have additional boards outside of the office which stipulate which staff are actually on duty. Each individual bedroom have notices stating who their Consultant and Named Nurse are. | Both Ward Manager/Clinical Leads oversee and organise the health rosters which enable us to look at skill mix and take into account the safety of the ward, for example if we have Enhanced Observations or need to cover staff who are on sick or annual leave. We also liaise with Nurse Bank if we require additional staffing. Both wards also have therapeutic activities on the ward which are organised by the Occupational Therapists. If there is a particular need for activities this will be discussed in our daily report outs. |
| Vickie Peters | Forensic LD | I can confirm that all areas are recording the daily staffing | Yes, we employed occupational therapist and assistants to |

| | | | |
|---|---|---|---|
| Modern Matron | | report and identification of named nurse and doctor is near the bed of each individual patient. | support therapeutic activities on the wards and when required cover vacant duties through centralised bank and overtime etc |
| David Grocott Modern Matron | Newtondale Ward<br>Kirkdale Ward<br>Fulmar Ward<br>Lark Ward<br>Mallard Ward | All my wards have this information displayed | All my wards currently have the resources to manage and can all access therapeutic activities. |
| Mark Colledge Modern Matron | AMH Durham & Darlington Rehab & Recovery Services. | Daily staffing is reported recorded on a board which is located at the entrance to the ward / unit. This board also contains information in relation to Unit Manager and Modern Matron as well as providing a description of the roles. Information relating to Named Nurse and Doctor is provided on a board in individual patient bedrooms. | It is felt that the current staffing levels do provide adequate scope for therapeutic activity and safe management of the environment. Although minimum staffing resources can be achieved through a full staffing compliment there are times when activity may need to be cancelled as a consequence of individual patient need, generally as a result of relapse in mental and physical state necessitating increased input by nursing staff to individual patients. Although at these times, management of the situation to maintain a safe and therapeutic environment is sought with staff from other units, bank or in extreme cases sanctioning overtime to maintain service provision. |
| Diane McPartland Acting Modern Matron | Tier 4 CAMHS | All wards have a white board in entrance with daily staffing report on. Newberry & Westwood have plaques fitted at the side of the bedroom door with named nurse/ doctor information on. Evergreen currently provide this on a paper document, but are in the middle of redevelopment which includes adding the plaques to the side of the bedroom doors. | Yes |
| Kevin Stubbings Modern Matron | Westerdale North and South; Wingfield | Daily staffing is recorded on the board which is located at the entrance to the ward / unit. Laminated poster inside the bedrooms which clearly identifies named nurse and doctor. Procedure exists which defines the scope of the named nurse should there be any delay in due to shift patterns. | Yes. Occupational Therapist has been absent due to sickness which has impacted on therapeutic activity, individual has returned therefore this is improving. Problems being consistent with therapeutic activity due to the turnover of staff and sickness. |

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

**FOR GENERAL RELEASE** **ITEM 9**

# BOARD OF DIRECTORS

**Date of Meeting:** **Thursday 23 July 2015**

**Title:** **Progress Report on Francis 2 Action Plans**

**Lead Director:** **Martin Barkley, Chief Executive**

**Report for:** **To consider**

## This report includes/supports the following areas:

| **STRATEGIC GOALS:** | ✓ |
|---|---|
| **To provide excellent services working with the individual users of our services and their carers to promote recovery and well being** | ✓ |
| **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 our communities** | ✓ |
| **To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities** | ✓ |

| **CQC REGISTRATION: Outcomes (✓)** | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | | Staffing | | Supporting workers | |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | ✓ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

# BOARD OF DIRECTORS

**Date of Meeting:** **Thursday 23 July 2015**

**Title:** **Progress Report on Francis 2 Action Plans**

## 1. INTRODUCTION AND PURPOSE

1.1 The purpose of this report is to update the Board of Directors on progress with implementing the action plans arising from the Francis Report, for the period up to 30 June 2015.

## 2. BACKGROUND INFORMATION

2.1 The Board of Directors approved action plans in response to the Francis Report itself as well as separate action plans following staff and stakeholder engagement discussions.

## 3. KEY ISSUES

3.1 Progress continues to be made, as can be seen on the progress report attached as Annex 1. There are no serious exceptions or delays to highlight, albeit some slippage has occurred on some of the elements of the action plan.

3.2 Since my last report to the Board, Audit North have completed an audit of the Trust's implementation of action plans supporting its response to the Francis 2 report. The Auditors concluded a "Significant" Assurance level.

## 4. IMPLICATIONS / RISKS:

4.1 **Quality:** Implementing the action plans will improve the quality of care provided

4.2 **Financial:** None identified

4.3 **Legal and Constitutional:** None identified

4.4 **Equality and Diversity:** None identified

4.5 **Other Risks:** None identified

## 5. CONCLUSIONS

5.1 The attached progress update confirms progress with implementation of the action plans.

## 6. RECOMMENDATIONS

6.1 The Board of Directors is asked to receive and consider this report.

**Martin Barkley,**
**Chief Executive**

**ANNEX 1**

# REPORT OF THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY – RECOMMENDATIONS ACTION PLAN EXCEPTION REPORT AS AT 30 JUNE 2014

## ACTION PLAN RESPONSE TO FRANCIS REPORT JULY 2013 – SEPTEMBER 2013

| Rec. No. (Chapter No.) | Recommendation | Trust Response | Completed Yes / No | Comments |
|---|---|---|---|---|
| | **Patient, public and local scrutiny** | | | |
| | **Openness, transparency and candour**<br><br>**Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.**<br>**Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.**<br>**Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.** | | | |
| 174<br>Chapter 22 | Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information. | Agreed. The Trust is currently reviewing how it can provide better support to relatives of service users who have died through self injury. The Trust held a Kaizen event in March 2013 where a revised system for relative contact and support was agreed with a group including bereaved carers and family members. The new support arrangements are being gradually introduced with serious untoward incidents that occur since 1 July 2013.<br>**Action: Dir of N&G - July** | **YES** | However, the new arrangements have not been effective. New arrangements will be developed by December 2014.<br>**The new arrangements (Version 2) started March 2015.** |

## ACTION PLAN: RESPONSE TO STAFF ENGAGEMENT DISCUSSIONS ON THE FRANCIS REPORT JULY 2013 – SEPTEMBER 2013

| | Issue identified | Summary action | Link to existing work stream | Who | When | Completed Yes / No | Comments |
|---|---|---|---|---|---|---|---|
| Culture | | | | | | | |
| 37 | Learning lessons from when things have gone wrong. | • To ensure that all actions in SUI & complaint action plans are SMART. | Ian Parker Review Action Plan | EMT Directors | From July 2013 | **YES** | |
| | | • To implement escalation arrangements to help ensure that action plans are completed on time. | | Director of Nursing & Governance | From September 2013 | **YES** | |
| | | • To carry out a sample audit of completed actions to test for their efficacy. | | Director of Nursing & Governance | From October 2013 | **YES** | |
| | | • To review the ways in which lessons learned from complaints and SUI investigations are shared and learnt from. | | Director of Nursing & Governance | ~~March 2014~~ **March 2016** | ~~**YES**~~ **PARTIAL** | Review has been completed but has revealed significant change is required. This is the focus of a significant project. Project report October. Implementation November - March. |
| | | • To review the methodology of investigation of Level 5 SUIs to ensure that real lessons are learnt as a consequence of the findings of the investigation. | | Director of Nursing & Governance | ~~March 2014~~ | **YES** | Review has been completed but has revealed significant change is required. The remedial action required will be developed as a priority in 2014. |

# ACTION PLAN RESPONSE TO FRANCIS REPORT JANUARY 2014 – MARCH 2014

| Rec. No. (Chapter No.) | Recommendation | Trust Response | Completed Yes / No | Comments |
|---|---|---|---|---|
| | **Putting the patient first**<br><br>**The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.** | | | |
| | **Nursing** | | | |
| 199 Chapter 23 | Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient. | A review is currently being planned to collate and evaluate the information of nursing allocation through shift patterns across the inpatient areas. There are currently a number of named nurse and key nurse systems in operation within inpatient services and the review will identify the best models of nursing allocation. **Action: Dir of N&G - expected completion date Quarter 4 2013/14** | ~~**PARTIAL**~~ **YES** | **The Modern Matrons have fed back that the named nurse allocation systems are in place on the wards. This action is therefore complete and will be audited as part of the nursing staffing and contact time work in 2015/16.** |
| | **Caring for the elderly**<br><br>**Approaches applicable to all patients but requiring special attention for the elderly** | | | |
| 238 Chapter 25 | Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds:<br>• All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors.<br>• Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients. | • The review of nursing allocation systems will include observation of the therapeutic milieu within the inpatient areas and the levels of interaction between nurses, their patients, relatives and carers. Recommendations to | **YES** | Observation complete. |

| Rec. No. (Chapter No.) | Recommendation | Trust Response | Completed Yes / No | Comments |
|---|---|---|---|---|
| | • The NHS should develop a greater willingness to communicate by email with relatives.<br>• The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered.<br>• Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled. | improve therapeutic interaction will result from that review.<br>• The current methods of communication both with relatives and with General Practitioners at point of discharge are subject to current development work.<br>**Action: COO - completion date Quarter 4 2013/14** | **YES**<br>**~~NO~~**<br>**YES**<br>**The new arrangements have been substantially rolled out and the project team is monitoring and supporting the new way of working** | Re inpatients.<br>The community discharge letter template was developed in an RPIW in April. South Durham Affective Team were involved in the RPIW and piloted the template. The RPIW was reviewed up to the 90 day point and it was agreed the template could be rolled out. Further work has been done with other services – Redcar and Cleveland AMH Teams (Mark Rushforth), Tees CAMHS Teams (Brian Cranna), Northallerton West CMHT (Joanne Fawcett). Dr. Jane Leigh (who is leading this project) has been called back to the South Durham Team to discuss some concerns they now have about the letter template. Their principal issue was the time taken to find some of the |

| Rec. No. (Chapter No.) | Recommendation | Trust Response | Completed Yes / No | Comments |
|---|---|---|---|---|
| | | | | information required for the template within PARIS. Feedback from South Durham GPs has been universally positive – with 100% expressing satisfaction with the template letters. Likewise the feedback from patients has also been good, with service users reporting they find their copy letter understandable and helpful.<br><br>The template has (in October 2014) been developed by Dr. Jane Leigh and IT to enable a range of the appropriate information to be electronically pulled through into the template – saving clinical time. This goes most of the way to addressing the concerns of the South Durham Team.<br>Dr. Jane Leigh and her team have a roll-out plan that will enable delivery of the template letter to all teams by March 2015. This involves face-to- |

| Rec. No. (Chapter No.) | Recommendation | Trust Response | Completed Yes / No | Comments |
|---|---|---|---|---|
| | | | | face training, follow up visits and audit and review.<br><br>**The community discharge documents are fully electronic and sent via email to most surgeries within two working days. Service users are offered a copy. Stage one of the community roll-out plan is completed (39 community teams trained) and Stage two will be commencing in August 2015.** |
| | | • Information and progress updates on patient care are included in the development work to implement the findings of the 2011/12 CPA review.<br>**Action: COO - 2014** | **PARTIAL – Not yet 100% but much improved, remains part of the CPA project** | Care plans have been issued or re-issued on yellow paper to enhance the visibility and recognition for service users. To date over 4,000 yellow care plans have been issued in AMH services with other specialties following this initiative. The team is no longer counting the numbers issued as this involved a manual count by each team (this was necessary for 2013/14 |

| Rec. No. (Chapter No.) | Recommendation | Trust Response | Completed Yes / No | Comments |
|---|---|---|---|---|
| | | | | Quality Account). Following positive feedback it has now become standard practice to issue care plans (with the exception of pictorial versions) on yellow paper. Service users and carers have been invited by letter from the CPA lead to inform improvement work about CPA and care planning. This has led to productive communication from service users via letter, email and telephone (relatively small number of people). This practice is now well established in AMH and increasingly so in other specialties. |
| | **Coroners and inquests**<br><br>**Making more of the coronial process in healthcare-related deaths** | | | |
| 281<br>Chapter 14 | It is important that independent medical examiners and any others having to approach families for this purpose have careful training in how to undertake this sensitive task in a manner least likely to cause additional and unnecessary distress. | Agreed as above. As part of the improvement work for the support of, and communication with, relatives following serious untoward incidents, training for staff undertaking these functions has been identified and is currently being developed.<br>**Action: Dir of N&G - March 2014** | ~~**NO**~~<br>**YES** | **Roadshows have been held to introduce the processes for implementation of the Duty of Candour standards. Further training will be made available on request.** |

## ACTION PLAN: RESPONSE TO STAFF ENGAGEMENT DISCUSSIONS ON THE FRANCIS REPORT JANUARY 2014 – MARCH 2014

| | Issue identified | Summary action | Link to existing work stream | Who | When | Completed Yes / No | Comments |
|---|---|---|---|---|---|---|---|
| HR and organisational development | | | | | | | |
| 26 | Improve the effectiveness of supervision and annual appraisals leading to the development of effective Personal Development Plans which are acted upon. | To review clinical supervision arrangements and staff appraisal arrangements and consider the introduction of 360° feedback every three years for managers and leaders. | Not Applicable | **Director of Nursing & Governance and** ~~Deputy~~ Director of Human Resources & Organisational Development | **March 2016 The EMT in June 2015 agreed the basis for changing and implementing new Clinical Supervision arrangements**<br><br>**The new appraisal system has been agreed and will be implemented Directorate by Directorate before 31 March 2016** | **NO**<br><br>~~**PARTIAL**~~ **YES**<br><br>**YES**<br><br>**YES** | Clinical supervision arrangements outstanding.<br><br>**Review complete and implementation proposals endorsed by EMT.**<br><br>360°.<br><br>Staff appraisal. |
| Culture | | | | | | | |
| 38 | The Trust should take more steps to share best practice through, for example, networking. | To carry out a review of existing networks to identify what additional networks would be helpful. | Not Applicable | Chief Executive (with Service Development Managers) | March 2014 | **Work in progress** | Proposed list of Learning Sets developed as basis for discussion. Agreed. Will start to be implemented in Q3 2014. Subsequent |

| | Issue identified | Summary action | Link to existing work stream | Who | When | Completed Yes / No | Comments |
|---|---|---|---|---|---|---|---|
| | | | | | | | consideration deferred until July 2015. |

# ACTION PLAN: RESPONSE TO STAFF ENGAGEMENT DISCUSSIONS ON THE FRANCIS REPORT APRIL 2014 – JUNE 2014

| | Issue identified | Summary action | Link to existing work stream | Who | When | Completed Yes / No | Comments |
|---|---|---|---|---|---|---|---|
| Recovery Approach | | | | | | | |
| 11 | The Trust should place more emphasis on preventing service users' mental health deteriorating. | To embed early warning practice within clinical processes. | CPA Project | ~~CPA Project Manager~~ **Chief Operating Officer and CPA Project Manager** | ~~October 2014~~ **March 2016** | **PARTIAL** | With the emphasis on staying well and identification of early warning relapse indicators a service user workbook, "Staying Well Plan" has been developed and is being implemented with service users in Psychosis and EIP services in Stockton AMH and North Durham. This will be implemented in Hartlepool Psychosis Team commencing October 2014 and will continue with the roll-out of Model Line.<br><br>The Staying Well Plan is a service user held workbook that individuals complete with support from MH staff.<br><br>**The version of PARIS will go live from March 2016. This practice** |

| | Issue identified | Summary action | Link to existing work stream | Who | When | Completed Yes / No | Comments |
|---|---|---|---|---|---|---|---|
| | | | | | | | **will be fully embedded as part of that roll-out. As part of the Model Line roll-out this practice is being embedded in Psychosis teams. The rest of the teams will be live with this from March 2016.** |
| Service user and carer involvement | | | | | | | |
| 14 | Ensure that users and carers (groups) are involved appropriately at a strategic level. | To review how users and carers are engaged in strategic and governance groups in the Trust. | Not Applicable | Chief Executive | June 2014 | **PARTIAL Quotations being obtained to advise on AMH arrangements in D&D and Tees and review of arrangements in NY already underway** | Review completed. Significant gaps in AMH in all three localities which will be addressed in 2015. |
| CPA | | | | | | | |
| 22 | There should be greater oversight of care plans and intervention plans to ensure their appropriateness and effectiveness. | To develop and implement a structure and model for care planning and its monitoring. | Not Applicable | **Chief Operating Officer and** CPA Project Manager | March 2015 | **~~NO~~ YES** | Note new timescale as this will follow from the key priority of improving quality of recovery focused care plans. **Recovery focussed care planning training has been rolling out to AMH, EIP, Crisis and** |

| | Issue identified | Summary action | Link to existing work stream | Who | When | Completed Yes / No | Comments |
|---|---|---|---|---|---|---|---|
| | | | | | | | **MHSOP teams across the Trust, based on a person centred model. A care plan audit has been developed and is used in conjunction with Model Line development in Psychosis and EIP teams.** |
| Staff feedback and involvement (including staffing reviews) | | | | | | | |
| 44 | Clarify roles and expectations of Ward Managers. | This piece of work is underway and will be implemented. | Project being established | Chief Operating Officer | ~~June 2014~~ **September 2015** | **PARTIAL PM3 agreed** | **This project is now under way. A role description, revised skills matrix and a programme of standard work development has been developed. The clarification of roles has been delivered as part of this work. This now needs to be fully communicated to ward managers.** |
| 47 | Ensure that Modern Matrons have sufficient time to focus on professional nursing issues. | To review individual jobs of Modern Matrons to identify if there are any duties they have that can be better done by others to free up time. | Modern Matron Workplan | ~~Deputy~~ Director of Nursing **& Governance** | March 2015 | ~~**PARTIAL**~~ **YES** | **Review complete and recommendations made – will be progressed with the work on the standardisation of the role of ward managers.** |
| 48 | Lack of consistent leadership model of community teams including | To establish a leadership model for community teams. | Not Applicable | Chief Operating Officer | ~~June 2014~~ **March 2016** | **PARTIAL Draft PM3 rejected** | **Leadership model has been developed and the project has begun** |

| | Issue identified | Summary action | Link to existing work stream | Who | When | Completed Yes / No | Comments |
|---|---|---|---|---|---|---|---|
| | Advanced Practitioner role. | | | | | **and basis of revised version to be agreed** | **roll-out in Durham and Darlington. Events are planned to expand this to other localities during 2015/16.** |
| *HT | Implement Friends and Family Test by December 2014 | • Establish arrangements and agree date for implementation. | Patient Experience | Director of Nursing & Governance | June 2014 | ~~**PARTIAL**~~ **YES** | **Complete** |

*HT refers to “Hard Truths” report published by the Government which sets out their response to the Francis and associated reports.

## ACTION PLAN RESPONSE TO FRANCIS REPORT OCTOBER 2014 – DECEMBER 2014

| Rec. No. (Chapter No.) | Recommendation | Trust Response | Completed Yes / No | Comments |
|---|---|---|---|---|
| 194 Chapter 23 | As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such. | The Trust is currently awaiting guidance from the Nursing and Midwifery Council regarding the proposed nursing revalidation process. The current annual performance appraisal focuses on the requirements of each nursing post in relation to the knowledge and skills framework for that post. The appraisal process will be further developed to integrate the values based performance monitoring recommended by this report. **Action: Dir of HR and Dir of N&G - April 2016** | ~~**NO**~~ **PARTIAL The Trust's new appraisal system has been agreed and is being implemented over the next 9 months** | **The revalidation project is progressing and achieving target dates. Steering group is in place. Communication framework agreed. Engagement with regional group is active. No further progress can be made until the NMC announce the final requirements.** |

## ACTION PLAN: RESPONSE TO STAFF ENGAGEMENT DISCUSSIONS ON THE FRANCIS REPORT OCTOBER 2014 – DECEMBER 2014

| | Issue identified | Summary action | Link to existing work stream | Who | When | Completed Yes / No | Comments |
|---|---|---|---|---|---|---|---|
| 7 | Develop on-line methods that enable patients and carers to more easily give feedback. | To develop apps and on-line solutions via the Trust's website for patient and carer feedback. | Knowledge Management Project | Patient Experience Lead Nurse | March 2016 | **NO** | This cannot be implemented with our existing website's lack of functionality. In addition the development of the Business Case re. Apps, etc. has been postponed to the summer. Therefore |

| | Issue identified | Summary action | Link to existing work stream | Who | When | Completed Yes / No | Comments |
|---|---|---|---|---|---|---|---|
| | | | | | | | need to agree revised date of March 2016. **The requirements regarding functionality of the website have been fed into the KMS project.** |
| Recovery Approach | | | | | | | |
| 13 | Lack of service user involvement in recruitment and selection of new staff. | This will be rectified as part of the Embedding Recovery Approach project. | Embedding Recovery Approach project | Recovery Approach Project Manager | ~~December 2014~~ **October 2015** | ~~**NO**~~ **PARTIAL** | **There is evidence of some participation in recruitment by service users. This is not as yet systematic. Standards for the routine involvement of service users will be drawn up and agreed by HR.** |
| CPA | | | | | | | |
| 16 | In the context of reducing paperwork completed by clinicians, etc. review whether the skill-mix is correct in community and ward teams between clinical staff and admin staff. | Agreed review to be undertaken. | CPA project Model Lines Project | Chief Operating Officer | ~~Dec 2014~~ **March 2016** | ~~**NO – MAINLY**~~ **PARTIAL This is being revisited in the context of Digital Dictation** | **Initial work complete. However, further work has been identified to reduce care documents. This will be linked with the review of PARIS (electronic patient records). Initial workforce redesign has taken place within Model Line for Psychosis. EMT is scoping requirement for further work.** |
| Staff feedback and involvement (including staffing reviews) | | | | | | | |
| 46 | Invest in skills of staff of de- | The current LD | Violence and | Deputy Director | October 2014 | ~~NO~~ | **The force reduction** |

| | Issue identified | Summary action | Link to existing work stream | Who | When | Completed Yes / No | Comments |
|---|---|---|---|---|---|---|---|
| | escalating challenging behaviour and management of challenging behaviour. | challenging behaviour pathway is being adapted via an RPDW to be used in each Service division within the trust and staff provided with the skills to practise in this way. | Aggression Workstream | of Nursing | | **PARTIAL** | **project is on track and is achieving all targets. New skills in PBS are being rolled out and the training for management of violence and aggression is being reviewed with regard to developing new training to meet the Restrictive Practice requirements set by the DH. The challenging behaviour pathway is being spread as part of the project supported by a commissioner CQUIN this year.** |

## ACTION PLAN RESPONSE TO FRANCIS REPORT 2015 AND BEYOND + ONGOING ITEMS

| Rec. No. (Chapter No.) | Recommendation | Trust Response | Completed Yes / No | Comments |
|---|---|---|---|---|
| | **Information** | | | |
| 244 Chapter 26 | There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems:<br>• Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way.<br>• Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry.<br>• Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered.<br>• Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input.<br>• Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements.<br>Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards. | Agreed.<br>**Action: DoF - milestones up to March 2015** | **PARTIAL ONGOING** | The Trust continues to develop its electronic patient record (PARIS) and planned improvements will encompass a number of the points detailed in the recommendation. In addition the embedding of agreed patient pathways within PARIS together with the IIC development will provide a series of prompts, defaults and alerts which will contribute to safe and effective care.<br>**Development of the PARIS system continues with the Board of Directors agreeing in June to further investment to secure additional enhancements and improvements to the system.** |

## ACTION PLAN: RESPONSE TO STAFF ENGAGEMENT DISCUSSIONS ON THE FRANCIS REPORT 2015 AND BEYOND + ONGOING ITEMS

| | Issue identified | Summary action | Link to existing work stream | Who | When | Completed Yes / No | Comments |
|---|---|---|---|---|---|---|---|
| Patient outcomes & Clinical outcomes (PROMS & CROMs) | | | | | | | |
| 2 | Ensure that effective use is made of the patient outcome reports. | To develop standard methodology for patient reported outcome measures to be reported back to services and other governance groups. | PBR Workplan | Director of Finance | December 2015 | **PARTIAL ONGOING** | This information is now available to each member of staff and Team Manager. Further work is taking place to encourage staff to use this information. Also consideration needs to be given to the role of management and the Board in this context. **Work continues to embed the use of Outcome measures within the Trust principally through reporting of CROM and PROM information via IIC.** |
| 3 | Trust patient pathways are based on NICE guidelines and that they are adhered to. | Variance analysis from the pathways will be undertaken. | Map of Medicine and Pathways Project Board | Director of Operations (Durham and Darlington) | **Ongoing** | **ONGOING** | **This work will never be completed – the development and implementation of pathways is happening and reviewed by the SDGs.** |
| Recovery Approach | | | | | | | |
| 10 | Improve patient outcomes by widespread use of the Recovery Approach. | To implement the Embedding the Recovery Approach | Embedding Recovery Approach Project | Recovery Approach Project Manager | 3 year project commencing Sept 2013 | **PARTIAL** | Project on track. |

| | Issue identified | Summary action | Link to existing work stream | Who | When | Completed Yes / No | Comments |
|---|---|---|---|---|---|---|---|
| | | project. | | | | | |
| 12 | The Trust should support appropriate therapeutic risk taking and consider whether too much emphasis is placed on defensive risk assessment. | To develop a Patient Safety Strategy with an objective to review present clinical risk management policy and practice. | Quality Strategy Workstream | Director of Nursing & Governance | Strategy by Dec 2013, Delivery of objective September 2015 | **YES** | **The PS Framework is in place as part of the Quality Strategy being monitored by the PS Group and the further workstreams on clinical risk management and harm minimisation are progressing.** |
| CPA | | | | | | | |
| 17 | Improve the effectiveness of the CPA process. | To implement the existing CPA project. | CPA project | CPA Project Manager | 2 year project commencing Oct 2013 | **PARTIAL** | Project on track. |
| 18 | Ensure that no unnecessary information is requested to be collected by frontline staff. | To review all present requests for data collection. | CPA project | CPA Project Manager | 2 year project commencing Oct 2013 | **PARTIAL** | Project on track. |
| 19 | Ensure there is a clear understanding and expectation of the role of the Care Co-ordinator. | This work is being undertaken as part of the CPA project. | CPA project | CPA Project Manager | 2 year project commencing Oct 2013 | **PARTIAL** | Project on track. |
| 20 | Staff in specialist services such as ADHD, Eating Disorders, Autistic Spectrum should take on care co-ordination role when appropriate to do so. | This is being addressed as part of the CPA project. | CPA project | CPA Project Manager | 2 year project commencing Oct 2013 | **PARTIAL** | Project on track. |
| 21 | Increase the user friendliness of PARIS. | To ensure that agreed changes to PARIS happen quickly resulting in standard work and that the training of staff is improved regarding | Patient Domain within Information Strategy | Director of Finance | Ongoing | **ONGOING** | A new upgraded version of PARIS was introduced in 2014 and a further upgrade is planned. **Further upgrades and enhancements to the system have taken** |

| | Issue identified | Summary action | Link to existing work stream | Who | When | Completed Yes / No | Comments |
|---|---|---|---|---|---|---|---|
| | | that standard work. | | | | | **place in 2015 and are also scheduled over the next 12 months. This will be combined with an amendment to the training approach to ensure the use of PARIS is relevant to the needs of services and that best practice is embedded in each team.** |
| HR and organisational development | | | | | | | |
| 29 | Identify people with an interest in moving to positions of management and leadership. | This is being addressed as part of the introduction of talent management arrangements in the Trust. | Talent Management Workstream | Chief Executive | March 2015 | **PARTIAL** | **60% of talent conversations have taken place for Band 7s and above and TM training now being provided for similar conversations to be had with Band 6s.** |

**ITEM 10**

# BOARD OF DIRECTORS

**Date of Meeting:** **Thursday 23rd July 2015**

**Title:** **To consider the progress against the action plan in response to the fifth overarching report from Malcolm Rae into the deaths of four patients of the Derwentside Affective Disorder Team in February 2013.**

**Lead Director:** **Chris Stanbury, Director of Nursing and Governance**

**Report for:** **Assurance/Information**

## This report includes/supports the following areas:

| **STRATEGIC GOALS:** | ✓ |
|---|---|
| **To provide excellent services working with the individual users of our services and their carers to promote recovery and well being** | ✓ |
| **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 our communities** | |
| **To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities** | ✓ |

| **CQC REGISTRATION: Outcomes (✓)** | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | ✓ | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | ✓ | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | ✓ | Cleanliness and infection control | | Management of medicines | ✓ |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | ✓ | Staffing | | Supporting workers | ✓ |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | ✓ | Complaints | ✓ |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | |
| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
| **Yes** | ✓ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

**BOARD OF DIRECTORS**

**Date of Meeting:** **Thursday 23rd July 2015**

**Title:** **To consider the progress against the action plan in response to the fifth overarching report from Malcolm Rae into the deaths of four patients of the Derwentside Affective Disorder Team in February 2013.**

## 1. INTRODUCTION & PURPOSE

1.1 The purpose of this report is to inform the Board of Directors of the progress against the action plan agreed in response to the overview report provided by the external reviewer of the deaths in February 2013 of 4 patients in Derwentside.

## 2. BACKGROUND INFORMATION

2.1 Further to the provision of the serious untoward incident reports on the 4 patients who died in February 2013 by the external reviewer, a fifth overview report was produced to identify more strategic developmental issues for the Trust to address. The action plan that was agreed in response to this report has been reviewed and the progress update is provided at Appendix 1.

## 3. KEY ISSUES:

3.1 The majority of the improvements recommended were longer term developmental work streams rather than short term amendments to current processes, these results in much longer timescales to take account of organisational change required. The majority have been completed or on track for completion to target dates.

3.2 Within the plan all the items due for completion in Quarter 1 2015/16 have been achieved other than:

**Item 7**- the item was initially delayed due to lack of senior capacity in the N&G Directorate in 14/15 – the review was re-established and completed in Q4 2014/15 together with a baseline audit of compliance against the current policy. The issues that were raised regarding implementation and capacity to deliver a different model of supervision led to some further work that was presented, as proposed policy changes, to EMT in June 2015. It has been agreed that the implementation plan should include detailed scoping of what is required to ensure compliance with a new policy – including capacity/skills of supervisors, organisational development and training. This scoping will be presented back to EMT by the end of Q3 for a decision regarding the progression of a revised policy and new model, as this may require additional resource.

3.3 **Items 1b and 4** are on track for completion – the Clinical Risk workstream has been progressed with a framework for Clinical Risk and Harm Minimisation approved by the Clinical Leaders Board and ratified by EMT. An implementation project has been scoped that will include the Suicide Prevention training and development of formulation based approaches. This is being presented to EMT for support on July 22nd.

## 4. IMPLICATIONS/RISKS:

4.1 **Quality:** Learning lessons is an essential element of quality improvement and quality assurance for the Trust. This action plan represents a significant area of learning lessons in relation to patient safety.

4.2 **Financial**: Resources for implementation to date have been identified to be met on non recurrent basis through projects or have been met within existing resources. The scoping work for implementation of new clinical supervision models and the Clinical Risk and Harm Minimisation frame work may highlight workforce capacity and competency risks that require investment.

4.3 **Legal and Constitutional:** The Care Quality Commission, Monitor and the Trust commissioners are tracking the Trust response to these SUIs and the actions being undertaken by the Trust to improve the safety and effectiveness of services.

4.4 **Equality and Diversity:** There are no direct risks or implications to equality and diversity requirements.

## 5. CONCLUSIONS

5.1 The action plan was agreed by the Board that demonstrates how the Trust is implement improvement from the lessons learned from the reviews of the 4 deaths in February 2013. Progress continues to be made against the plan with a number of actions completed on target for Q1 2015/16. One workstream is on track for completion as planned for September 2015.

5.2 One outstanding action not completed is the development and implementation of a new clinical supervision policy and supportive practice.

5.3 Several of the areas that are included in the plans are fundamental practices in the Trust such as the clinical risk framework, suicide prevention, serious incident review, carer engagement and supervision models. Improvement plans in these areas need to be robust and are requiring ongoing significant commitment and capacity to ensure change and embedding into routine operational activity. .

## 6. RECOMMENDATIONS

6.1 The Board of Directors is requested to note the progress against the action plan as outlined in Appendix 1.

6.2 The Board of Directors is asked to agree to receive specific quarterly updates on the workstreams for Clinical Supervision and Clinical Risk and Harm Minimisation.

6.3 The Board of Directors is requested to sign off this Rae 5th Report Action plan as complete, with the caveat that those ongoing workstreams will be monitored as proposed in 6.2.

**Chris Stanbury, Director of Nursing and Governance**

**APPENDIX 1**

## ACTIONS TO MEET OVERVIEW REPORT RECOMMENDATIONS FROM THE EXTERNAL REVIEW OF THE FOUR DEATHS OF SERVICE USERS IN FEBRUARY 2013

**PLAN LOCATION/TEAM:** Trustwide **PLAN DEVELOPED BY:** Chris Stanbury, Director of Nursing and Governance
**DATE PLAN AGREED:** September 2013

| NO. | RECOMMENDATION/ FINDING | INTENDED OUTCOME/ RESULT | LEVEL OF ACTION | ACTION | ACTION OWNER | TARGET DATE FOR ACTION COMPLETION | EVIDENCE (TO BE RETAINED BY ACTION OWNER) | PROGRESS UPDATE June 2015 |
|---|---|---|---|---|---|---|---|---|
| 1 | To develop and implement a more systematic, formulation driven and better informed approach to risk assessment and safety management. | A formulation based model of Clinical Risk Assessment and Management will be implemented across all clinical services by 30 September 2015. | Trustwide | a To establish a workstream to review and redesign the current Trust model and policy for clinical risk assessment and management (CRAM) | Director of Nursing and Governance | 31 March 2014 | Workstream scope and plan | **COMPLETE** Workstream has been agreed and will be monitored through the Patient Safety Sub-Group to QuAC. Workstream being led by the SCD Forensic Services |
| | | | | b To implement the new model of CRAM | Director of Nursing and Governance | 30 September 2015 | Revised CRAM policy. New risk assessment documentation. Implementation plan. Compliance audit report. | **Ongoing** – the overarching Clinical Risk and Harm Minimisation framework has been approved and the implementation programme has now been scoped . The Suicide Prevention workstream has been integrated into this programme and work will be in progress by the target date. |
| 2 | To improve the assessment and management model of suicidal risk. | A Trustwide model for the training, prevention and management of suicide risk will be implemented across all AMH services by 31 March 2015 | Initially AMH services then Trustwide | To design and implement a model for suicide risk assessment and management prevention, initially in AMH. | Director of Nursing and Governance | ~~31 March 2015~~ 30 June 2015 | Baseline audit report. New Suicide RAP model. Implementation Plan. Audit | **COMPLETE** Model agreed and agreed scope of training complete. Work has now been integrated into the Risk Management and Harm Minimisation work Trustwide.(see above) |

| NO. | RECOMMENDATION/ FINDING | INTENDED OUTCOME/ RESULT | LEVEL OF ACTION | ACTION | ACTION OWNER | TARGET DATE FOR ACTION COMPLETION | EVIDENCE (TO BE RETAINED BY ACTION OWNER) | PROGRESS UPDATE June 2015 |
|---|---|---|---|---|---|---|---|---|
| **3** | To evaluate current models of observational practice in risk management and audit compliance with Engagement and Observation Policy in AMH in-patient areas. | To have a quantitative policy compliance level of current observational practice and a descriptive review of current practice by March 2015. | AMH in-patient services Trustwide | To design observational audit and practice review | Director of Nursing and Governance (Head of Clinical Effectiveness | ~~As in 2014/15 Clinical Audit Plan Report completion March 2015~~ **30 June 2015** | Audit and practice report | **COMPLETE** **Clinical audit completed.** Clinical audit findings will be used to further inform policy development. New NCI report 'IN-PATIENT SUICIDE UNDER OBSERVATION' will be used to support practice development as part of the CR&HM framework |
| **4** | To develop and implement a competency based model of risk assessment and safety management training. | To have implemented an approved training model for clinical risk assessment and management by September 2015. | Trustwide | To design a training syllabus, competency assessment and implementation plan for clinical risk assessment and management | Director of Nursing and Governance (Head of Patient Safety) | 30 September 2015 | Training programme. Course syllabus. Assessment framework. Implementation plan. Training registers | **Ongoing** – on track for completion (see 1b) |
| **5** | To review the availability and accessibility of bereavement counselling for service users. | To have an agreed signposting process for service users to access specific bereavement counselling by March 2014. | Trustwide | To review the availability and accessibility of bereavement counselling for service users and produce an asset register | Chief Operating Officer (Head of Psychology and Psychological Therapies | 31 March 2014 | ~~Register of services in each Trust locality~~. Signposting service | **COMPLETE** Agreed signposting process to those services by Trust available through psychological services. |
| **6** | To evaluate the implementation of supervision of clinical practice in adult mental health in-patient areas | To have audited the policy compliance in AMH in-patient areas of clinical supervision | AMH in-patient services Trustwide | To design and implement an audit tool for supervision in AMH in-patient areas | Director of Nursing and Governance (Head of Clinical Effectiveness) | As in 2014/15 Clinical Audit forward plan. | Audit Report | **COMPLETE** |

| NO. | RECOMMENDATION/ FINDING | INTENDED OUTCOME/ RESULT | LEVEL OF ACTION | ACTION | ACTION OWNER | TARGET DATE FOR ACTION COMPLETION | EVIDENCE (TO BE RETAINED BY ACTION OWNER) | PROGRESS UPDATE June 2015 |
|---|---|---|---|---|---|---|---|---|
| **7** | To include peer review in the supervision and support framework for complex cases in AMH in-patient areas | To have implemented a new model of supervision for complex cases in AMH by 31 March 2015 | AMH in-patient services Trustwide | a To review and update supervision policy to reflect peer review to be used in in-patient areas | Director of Nursing and Governance (Deputy Director of Nursing) | ~~30 September 2014~~ ~~28 February 2015~~ **30 June 2015** | Revised policy | The new model was presented to EMT in June 2015 with the implementation plan . Based on baseline audit results regarding compliance with the current supervision policy, there are significant training and operational implementation issues that require further scoping . This scoping work is aimed to be complete by September 2015 and further implementation led by operational service based Heads of Nursing, Deputy Medical Directors, AHP and Psychology Leads . In the interim some complex case discussion work has commenced in in-patient wards and community teams linked to formulation work. |
| | | | | b To implement a new policy model | Chief Operating Officer | **31 July 2015** | Implementation Plan. Audit report. | *See above* |
| **8** | To evaluate the availability of experienced clinical staff with competency and capability to provide support and guidance to less experienced staff | To have a model to identify the experience within the skill mix in clinical teams by 31 March 2015 | Trustwide | To develop a survey tool to measure experience and skills of clinical staff.<br>To implement a support model within the supervised environment. | Chief Operating Officer | 31 March 2015 | Skills report. Implementation plan. | **COMPLETE – within model line and Hard Truths workstream** |
| **9** | To develop and implement a model of Level 2 safeguarding adults training that focuses on application in clinical practice | To have a model of Level 2 safeguarding Adults implemented across all services by 30 June 2015 | Trustwide | a To design a training syllabus and role play exercises for use with in-patient AMH staff | Director of Nursing and Governance (Head of SGA) | a 30 June 2014 | Training syllabus. | **COMPLETE** |

| NO. | RECOMMENDATION/ FINDING | INTENDED OUTCOME/ RESULT | LEVEL OF ACTION | ACTION | ACTION OWNER | TARGET DATE FOR ACTION COMPLETION | EVIDENCE (TO BE RETAINED BY ACTION OWNER) | PROGRESS UPDATE June 2015 |
|---|---|---|---|---|---|---|---|---|
| | | | | b To implement training programme across AMH | Director of Nursing and Governance (Head of Safeguarding Adults) | b 30 June 2015 | Training records. Training evaluation | **COMPLETE** |
| **10** | To evaluate the current approaches to medication concordance and produce a range of proposals for improvement | To have a range of proposals available for improving medication concordance | Trustwide | To implement a medication management review | Chief Operating Officer (Chief Pharmacist) | 30 September 2014 | Evaluation report | **COMPLETE** |
| **11** | To implement an audit of the discharge planning process and checklist in use in adult mental health in-patient units | To have completed an audit of discharge planning in AMH in-patient services | AMH in-patient services Trustwide | To design and implement an audit tool to evaluate the current discharge process and agree action if indicated | Director of Nursing and Governance (Head of Clinical Effectiveness) | As in ~~2014/15~~ **2015/16** Clinical Audit forward plan | Audit report | Was deferred as QIS work was ongoing on discharge process.<br>To be completed as part of 2015/16 Audit Programme<br><br>**COMPLETE. Clinical audit completed.** |
| **12** | To evaluate the systems and resources required to enhance support, family engagement and follow up in the 48 hours post discharge from AMH in-patients | To have evaluated the post discharge systems for family support from AMH in-patient services by 30 June 2014 | AMH in-patient services Trustwide | To establish a project to achieve the evaluation and develop model of post discharge support | Chief Operating Officer | 30 June 2014 | Project plan and process complete | **COMPLETE** |
| **13** | To appraise the current carer strategy and ensure that the principles in the Triangle of Care carer guidance are understood and comprehensively implemented | To have implemented a Carer's Strategy that incorporates the Triangle of Care guidance | Trustwide | a The Carers' Strategy will be reviewed and amendments developed as required | Director of Nursing and Governance (Head of Complaints, PALS and PPI) | 31 March 2014 | Revised Carers' Strategy | **COMPLETE** |

| NO. | RECOMMENDATION/ FINDING | INTENDED OUTCOME/ RESULT | LEVEL OF ACTION | ACTION | ACTION OWNER | TARGET DATE FOR ACTION COMPLETION | EVIDENCE (TO BE RETAINED BY ACTION OWNER) | PROGRESS UPDATE June 2015 |
|---|---|---|---|---|---|---|---|---|
| | | | | b A revised implementation plan will be delivered for the Carers' Strategy that will include staff briefing on the principles of the Triangle of Care (TOC) | | 31 March 2015 | Implementation Plan | **COMPLETE –** |
| | | | | c. Each ward will identify a Triangle of Care champion to ensure staff on that ward understand the strategy | | 31st October 2014 | Network lists for TOC champions | **COMPLETE** |
| **14** | To have systems to better support relatives and carers post patient death | To have comprehensive systems of carer involvement and support post SUI implemented by September 30 2014 | Trustwide | To hold Kaizen event to revise and improve systems. To establish implementation system with monitoring of efficacy | Director of Nursing and Governance (Head of Patient Safety) | 30 September 2014 | Standard work. Implementation system. Audit report | **COMPLETE** |
| **15** | To review the current models of practice in community mental health teams – particularly the role of the consultant psychiatrist on the team | To have reviewed the CMHT models of practice and produced report by 30 September 2015 | Trustwide | To establish and deliver workstream and review models and roles and responsibilities | Chief Operating Officer | 30 September 2014 | Review report | **COMPLETE** |
| **16** | To review workload and caseload management of care co-ordinators | To have reviewed the workload and caseload of care co-coordinators by 31 March 2015 | Trustwide | To establish and deliver workstream within CPA project | Chief Operating Officer (CPA project manager) | 31 March 2015 | Workstream review report | **COMPLETE** |

| NO. | RECOMMENDATION/ FINDING | INTENDED OUTCOME/ RESULT | LEVEL OF ACTION | ACTION | ACTION OWNER | TARGET DATE FOR ACTION COMPLETION | EVIDENCE (TO BE RETAINED BY ACTION OWNER) | PROGRESS UPDATE June 2015 |
|---|---|---|---|---|---|---|---|---|
| **17** | To review the skill mix and capabilities of community affective disorders teams with respect to workload management and skills in managing patients with BPD | To have completed review of AMH Affective Disorders Teams by 30 September 2015 | AMH affective teams Trustwide | To establish workstream to review skill mix and workload management in affective disorder teams in each community locality | Chief Operating Officer (Directors of Operations in each locality) | 30 September 2014 | Workstream review report | **COMPLETE** |
| **18** | To review access to psychological therapies as indicated in NICE guidelines and cluster intervention requirements | To have completed review of Psychological Therapies capability and capacity in accordance with NICE guidelines by 30 September 2014 | Trustwide | To implement psychological therapies capability and capacity review across all AMH services against NICE guideline requirements and PBr Cluster intervention requirements | Chief Operating Officer (Head of Psychology and Psychological Therapies) | 30 September 2014 | Capability and capacity report | **COMPLETE** |
| **19** | To complete the work to improve engagement of GPs in the review of Serious Untoward Incidents | To have agreed a plan with CCGs to improve engagement of GPs in SUI reviews by 30 September 2014 | Trustwide | To work with CCG commissioners to further engage GPs with regard to the SUI review process | Director of Nursing and Governance (Head of Patient Safety) | 30 September 2014 | Action plan. Review report | **COMPLETE -**within influence of Trust. CCGs will need to take f/w any further work. |
| **20** | To develop a SMART action plan to facilitate implementation of the solutions generated at the Learning Event held on 28 June 2013 | To have a SMART action plan to ensure all lessons learned from the Learning Event are spread across all AMH services Trustwide by 30 June 2014 | AMH services Trustwide | To review all the feedback from the Learning Event of 28 June and develop an action plan to facilitate the implementation of changes required from that feedback across AMH services | Chief Operating Officer (Senior Clinical Director AMH Speciality Development Group) | 30 June 2014 | Action plan is available | **COMPLETE** |

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

**BOARD OF DIRECTORS**

**ITEM 11**

**Date of Meeting:** **Thursday 23 July 2015**

**Title:** **Nicotine Management & Smoking Cessation Project**

**Lead Director:** **Dr Nick Land, Medical Director**

**Report for:** **Assurance**

## This report includes/supports the following areas:

| **STRATEGIC GOALS:** | ✓ |
|---|---|
| **To provide excellent services working with the individual users of our services and their carers to promote recovery and well being** | ✓ |
| **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 our communities** | ✓ |
| **To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities** | ✓ |

| **CQC REGISTRATION: Outcomes (✓)** | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | ✓ | Consent to care and treatment | ✓ | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | ✓ | Meeting nutritional needs | | Co-operating with other providers | ✓ |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | ✓ | Cleanliness and infection control | ✓ | Management of medicines | ✓ |
| Safety and suitability of premises | ✓ | Safety, availability and suitability of equipment | ✓ | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | ✓ | Staffing | ✓ | Supporting workers | ✓ |
| **Quality and management** | | | | | |
| Statement of purpose | ✓ | Assessing and monitoring quality of service provision | ✓ | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | ✓ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

# PM3 – BUSINESS CASE

| | |
|---|---|
| **Project:**<br>Nicotine Management & Smoking Cessation | **Project ID:**<br>MED 13.02 |
| **Author(s):**<br>Lesley Colley, Phillip Darvill, Clare Cuthbertson | **Project Level:**<br>2 |
| **Project Sponsor:**<br>Nick Land | **Date:**<br>26/05/2015 |

## 1. Document Purpose

This document has been developed to seek approval from EMT to implement the project, the scope of which was agreed by EMT on 10 June 2015.

## 2. Changes to Strategic and Operational Context since Scope Approval

Following approval of the PM1 scoping document in December 2014 there have not been any changes in the strategic or operational context in relation to this project.

## 3. What will be delivered?

This project will provide a strategic direction for smoking cessation and harm reduction within TEWV and a framework to deliver substantial progress on smoking cessation by March 2016.

It is clear that successful delivery of this project will require sustained senior clinical and managerial support alongside the Project Manager leading and co-ordinating the project work streams.

If successful this project will deliver:

- The implementation of NICE Public Health Guideline 48;
- A framework to deliver smoking cessation and harm reduction within TEWV;
- Support national and local CQUIN targets;
- Support for the Trust's Physical Healthcare Project

The project will align and deliver the approved and published actions identified within the Trusts 2015-2018 Business Plan and 2014/15 Quality Account, which are:

**We will:**

- Appoint a Project Manager for the Nicotine Management and Smoking Cessation Project by quarter 1 2015/16.
- Develop a communications plan to inform staff and service users of the Trust's plans to implement its policy on Nicotine Management and Smoking Cessation by quarter 1 2015/16.
- Identify potential/available alternatives to smoking/nicotine and understand mechanisms for prescribing by quarter 1 2015/16.
- Have used the Baseline Assessment Tool (identified within the NICE Public Health guidance 48 (PH48) on smoking cessation) to ensure that the Trust's practice is in line with recommended NICE guidance by quarter 1 2015/16.
- Complete a benchmarking exercise to understand the number of staff smokers in order to set targets for reduction by quarter 2 2015/16 and then monitor performance against those targets in future quarters.
- Work with our Local Authority Smoking Cessation services to host clinics at key Trust localities (such as Roseberry Park or Lanchester Road) by quarter 2 2015/16.
- Advertise, promote and maximise the opportunity provided by Stoptober 2015 by quarter 3 2015/16.
- Review our No Smoking Policy to incorporate Nicotine Management and Smoking Cessation by quarter 3 2015/16.
- Develop an implementation plan to support staff to stop smoking by quarter 3 2015/16.
- Have sufficient staff trained in Nicotine Management and Smoking Cessation pilot sites in each of our localities to sustain the delivery of our smoke free agenda within the pilot sites by quarter 4 2015/16.
- Implement the Trust's standards on Nicotine Management and Smoking Cessation as per the new / revised approved policy by quarter 4 2015/16.

The project will also be updating and developing the No Smoking Policy. There are several areas under discussion such as:

- the potential introduction of e-cigarettes for service users,
- staff unable to smoke in uniform (what serves as uniform!),
- there will no longer be any exceptions to the policy (the policy currently includes exceptions if staff wish to make special arrangements to allow service users to smoke on a Trust site),
- official and unofficial breaks for smoking,
- clarity on "reasonable time" for staff to access stop smoking support (the recommended time is 4 hours total over 12 weeks support),
- penalties for staff smoking during working hours,
- staff support to challenge service users smoking on Trust premises.

Further information on what has been delivered to date can be found within **appendix 1**.

## 4 Project Benefits

The 2010 Health Survey for England found that smoking prevalence amongst people with a long standing mental health disorder was 37% compared to 20% in the general population.

Following the smoking ban in public places a survey of mental health units took place in 2007 by Ratschen, Britton and McNeill which cited advantages such as:

- reduced exposure of patients and staff to second-hand smoke,
- an enhancement in patients' motivation to stop smoking,
- better sleeping patterns among patients.

Prochaska (2011) identifies the long standing perception that people with a mental illness are less able or less willing to quit smoking. Should the introduction of VBA training become mandatory to all staff and indeed the advanced training for selected staff on each ward/unit staff will gain the knowledge required to identify a smoker, offer advice and refer/assess for pharmacotherapy support on routine admission to secondary care.

Banham & Gilbody (2010) stated that:

> *"Stop smoking support offered to smokers with a mental illness was as successful as that offered to smokers in the general population and cessation did not lead to worsened mental health state".*

Hall & Prochaska also identified that following a successful quit attempt, lower levels of anxiety are reported amongst former smokers which contradicts the belief that cessation will lead to an exacerbation of mental health symptoms. This reduction in anxiety could well lead to a reduction in violence and aggression therefore future audit is identified within the project plan to look at service user behaviour following the smoke free implementation and will provide valuable data regarding this.

Inevitably less time may be taken supporting service users' smoking breaks if they quit but there could be an increase in the time taken to offer the regular use of the e-cigarette to prevent nicotine withdrawals. A decision is required as to where a patient can use the e-cigarette but the consensus to date is to allow use within individual bedrooms or outside areas. Ultimately the potential aim of the e-cigarette use will be to allow greater time to engage in therapeutic activities. Regular supplies of nicotine will help to reduce the agitation often experience by those stopping smoking and limit the withdrawals commonly experienced during smoking cessation. The potential reduction in the dose of specific drugs such as Clozapine could also have a beneficial financial impact on the Trusts drugs budget, although the increase in essential blood testing may impact on any realised cost benefits. These potential cost reductions could be further assessed approximately 6 months after the project is complete as part of the benefits realisation. SLaM have identified that patients with severe psychosis using Clozapine and Olanzapine commonly do not have any

reduction in medicine regime but are more effectively treated. The cost benefit associated with this is a reduced length of hospital stay.

In the long term, should staff stop smoking, there is also a definite possibility of a reduction in staff sickness due to an improvement in their general health, which could have a beneficial impact on the Trust workforce. Future audit post smoke free implementation will give a more accurate guide as to staff sickness levels and identify any possible reduction linked to the smoke free agenda.

Ultimately the reduction in life expectancy amongst people with serious mental illness is attributable to smoking (Royal College of Physicians 2013) thereby it has been proven that becoming a smoke free Trust will benefit both the service users and staff and lead to an increase in life expectancy.

## BENEFITS

| Strategic Goal | Benefit | Metric | | Benefit Owner *(individual responsible for realising the benefit* | Data Source *(e.g. PARIS, Patient Survey)* | Data Collection Frequency *(e.g. quarterly)* | Baseline and Target | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Code | Description | | | | Current Position | What period (e.g. Qtr. 1 13/14) | Future Target | By When |
| | | | | | | | | | | |
| 1 | Reduction in smoking (Inpatient units) | | Improvement in both short and long term health and reduction in second hand smoke exposure | Project Manager | PARIS data Staff & Patient survey | Monthly initially then quarterly | Analysis underway to determine current baseline | | 75% | Q4 2015/16 |
| 3 | Reduction in staff smoking in buildings and grounds | | Improved short and long term health benefits and reduced exposure to second hand smoke | Project Manager | Occupational Health data/staff survey/FFT | Bi-Annually | | | 90% | Q4 2015/16 |
| 3 | Reduction in violence and aggression from service users | | % reduction in recorded violent incidents across TEWV | Project Manager | RIDDORs Datix | Quarterly | Evidence (from other Trusts who have implemented a smoke free policy) has shown that these benefits can be quantified during and following becoming smoke free. Although TEWV does not have any evidence as yet, the Project Manager will assess against these potential benefits as the project progresses | | To be determined | Q4 2015/16 |
| 3 | Less time taking service users out for cigarette breaks | | Staff no longer exposed to second hand smoke | Project Manager | Staff Survey | Quarterly | | | | Q4 2015/16 |
| 1 | More time to deliver activities for service users | | Increase in therapies delivered to service users therefore increasing wellbeing and potential earlier discharge | Project Manager | Staff & Patient surveys/forums | Quarterly | | | | Q4 2015/16 |
| 3 & 5 | Reduction in staff sickness if stop smoking | | % of sick days prior to and following the smoke free implementation | Project Manager | Finance/HR IIC | Bi-Annually/Annually | | | | Q4 2015/16 |
| 1 & 3 | Potential increase in the life expectancy of service users and staff | | Narrowing the gap on life expectancy | Project Manager | National guidance | Annually | | | | 2016 Q1 onwards |
| 5 | Reduction in the drug budget for specific medicines | | Potential cost saving to the Trust | Project Manager | Finance Pharmacy Budget | Quarterly | | | | Q4 2015/16 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 & 2 | Reduction in side effects by reducing the dosage of specific medicines | | Improved patient clinical outcomes and recovery | Project Manager | Pharmacy survey- including drugs which counteract side effects | Quarterly | As above | To be determined | Q4 2015/16 |

**DISBENEFITS**

| Strategic Goal | DisBenefits | Metric | | Benefit Owner *(individual responsible for realising the benefit* | Data Source *(e.g. PARIS, Patient Survey)* | Data Collection | Baseline | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Code | Title | | | Frequency *(e.g. quarterly, annually)* | Current Position | Period | Future Target | Period |
| | | | | | | | | | | |
| | Effect on Social Norms by using electronic cigarettes in communal areas | | May adversely impact on non smokers and staff | Project Manager | Patient/staff survey Focus groups | Quarterly | Evidence (from other Trusts who have implemented a smoke free policy) has shown that these benefits can be quantified during and following becoming smoke free. Although TEWV does not have any evidence as yet, the Project Manager will assess against these potential benefits as the project progresses | To be determined | | Q4 2015/16 |
| 3 | Potential increase in the turnover of staff due to the smoking ban | | Retainment and recruitment of staff may be of concern | Project Manager | HR-recruitment | Bi-Annually | | | | Q4 2015/16 |
| 2 & 5 | Increase in staff time issuing regular pharmacotherapies to service users | | Amount of additional staff time administering products | Project Manager | Audit on drug administration of pharmaco-therapies | Bi-Annually | | | | Q4 2015/16 |
| 5 | Increase in pharmacy budgets for Pharmacotherapies | | Total expenditure on pharmacotherapies | Project Manager | Pharmacy costs Contact Maudsley for their data | Quarterly | | | | Q4 2015/16 |
| 5 | Increase in the blood testing required for specific drugs such as Clozapine | | Increased costs for additional blood tests during smoking cessation | Project Manager | PARIS Laboratory services | Quarterly | | | | Q4 2015/16 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 3 | Additional hours required to train all staff in VBA (20 minutes each) And relevant clinical staff trained to Level 2 | | VBA -20 minutes per clinical staff member<br>Level 2 trained staff- 8-10 hours total | Project Manager | Training department data log | Annually | | Q1-Q4 2015/16 | 1.VBA 75%<br>2.level 2 75% | 1 and 2 Q4 2015/16 |

## 5. Option Appraisal

Option one – do nothing

This has great potential to see the gap in health widening for Mental Health service users in the long term and may impact on the delivery of the Quality Account and Business Plan priority actions. Currently people with severe mental health illness die 15-25 years earlier than the general population and by doing nothing we may see this impacting further. Our external stakeholders feel that this project is essential due to the reduction in life expectancy among people with mental health problems and by doing nothing we may ultimately continue to widen the gap.

As identified in the delivery element of this Business Case, the NHS already spends an estimated £720 million on treating smokers with mental health problems and this may continue to rise should we fail to take action to support the smoke free agenda.

Option two – implement NICE guidance

Implement the NICE PH 48 guidance "Smoking Cessation in Secondary Care-Mental Health Services" in full and provide a smoke free environment for staff, service users, relatives and visitors to the Trust. By implementing the guidance we will support the Business Plan and Quality Account priority actions and a total ban will complement the duty of care of healthcare staff and the organisation to protect the health of people in their care.

Although stopping smoking is associated with improvements in longer term mental health, evidence identifies both potential short term negative and positive effects (such as increased agitation or improvements in mood). Prompt provision of pharmacotherapies or electronic cigarettes can help to alleviate negative effects associated with nicotine withdrawal whilst the provision of intensive behavioural support will further support the effectiveness of treatment.

The Programme Development Group (PDG), whilst developing the NICE PH48 recommendations took account of a number of identified benefits of stopping smoking including: a reduction in the harms associated with second-hand smoke, a reduction in the costs of social care for people with smoking-related diseases, and the effect on the uptake of smoking among children. The PDG therefore identified that high-intensity stop smoking interventions are a highly cost-effective way of helping people to stop smoking.

There may be some initial cost implications attached to the development and delivery of specific elements of the smoke free agenda such as:

- Signage across sites;
- Information Leaflet costs;
- Increased drug budget for pharmacotherapies-Nicotine Replacement Products;
- Increase in blood testing for Clozapine levels;
- Staff training;

- Potential Investment of £5000 in Maudsley training package for 5,000 staff;

But in turn there may be reduced costs such as:

- Reduction in drug budgets i.e. Clozapine or Olanzapine dosages
- Reduction in antibiotic prescribing and medical staff time- (As seen in Maudsley where they noticed a reduction in costs associated with antibiotic prescribing that was attributed to the smoke free policy with a dramatic reduction in chest infections and a reduction by 50% of referrals to the GP for chest infections)
- Cost savings for staff escorts and transport costs along with medications for physical health conditions (Identified by Maudsley)

For more detail please see the Finance section identified below in **Section 8**.

The preferred option is **option 2**.

## 6. Market Assessment

Numerous other Mental Health Trusts have decided to go smoke free following the implementation of the NICE smoke free guidance in November 2013. Other Trusts carrying out similar pieces of work currently are listed below:

- South London & Maudsley (SLaM)
- Royal Devon & Exeter NHS Foundation Trust
- Northumberland, Tyne & Wear NHS Foundation Trust (NTW)
- Lancashire Care NHS Foundation Trust
- Rampton Hospital (part of Nottingham Healthcare NHS Foundation Trust)

| Trust: | Population served: | Square miles: | Employees: | Annual Income: | Sites: |
|---|---|---|---|---|---|
| TEWV | 1.67 million | 3,600 | 6,000 | £294 million | 180 |
| SLaM | 1.1 million | | 4,800 | £308 million | |
| Devon | 850,000 | | 2,500 | £130 million | |
| NTW | 1.4 million | 2,200 | 6,000 | £300 million | 60 |
| Lancashire | 1.4 million | 1,189 | 6,650 | £325 million | 400 |
| Rampton | | | 1,900 | | |

TEWV is geographically a much larger organisation than the named competitors and serves a greater population of 1.67 million. TEWV has similar staffing and income to NTW and Lancashire and therefore it would prove beneficial to communicate with both of these services regarding progress to date and any barriers to the delivery of the smoke free agenda. Discussions with the Trusts identified above has helped to shape the current focus on the smoke free agenda and provided information on similar goals linked to the improvement of physical health for Mental Health service users and staff.

## 7. Engagement

| Category | Person consulted | Date consulted/ mtg arranged | Outcome of consultation |
|---|---|---|---|
| Other clinical services from the Project group:<br>• Communications<br>• Modern Matrons<br>• Physical Health<br>• FRESH North East<br>• CPNs<br>• Human Resources<br>• Clinical/Medical Directors<br>• PHE<br>• Planning & Performance | Clare Cuthbertson<br>Fiona Punchard<br>Ann Thomas<br>Alexia Hardy<br>Martyn Wilmore<br>Bob Redfern<br>HR representative<br>Angus Bell<br>Nick Land<br>Jo Darke<br>Phil Darvill | Ongoing | Ongoing support throughout the project |
| Pharmacy | Chris Williams | Ongoing | Pharmacy supporting the implementation of the project through identification and development of potential pharmacological options available to the Trust |
| Finance | N/A | | |
| Capital | N/A | | |
| Estates | Linda Parsons | Ongoing | Estates supporting the implementation of the smoke free site including removal of smoking shelters and conversion of bike sheds |
| Information (hardware / software / data systems) | TBC | | |
| Information Governance (inc PIA) | Lynn Jackson | Ongoing | Information Governance supporting the decision to implement the Quit Manager system for |

| | | | |
|---|---|---|---|
| | | | collating service user data for DOH quarterly return |
| Equality and Diversity (including Equality Analysis) | Sarah Jay<br>Tracy Loynes | Ongoing | Equality and Diversity supporting the Equality Analysis Screening assessment linked to the development of the Smoke Free Policy |
| Human Resources | David Levy<br>Sheila Jones<br>Sheila Cowan | Ongoing | Human Resources supporting the development of the Smoke Free Policy and the links with commissioning and leadership |
| CQC Registration | N/A | | |
| Clinical Safety Officer | Head of patient safety | Ongoing | Clinical safety Officer supporting the development of the Smoke Free Policy |
| IPC and Physical Health Care | Alexia Hardy<br>Karen Conlon | Ongoing | Physical Health Care supporting the Smoke Free agenda |
| Performance (including changes to Plan / Activity) | Chris Lanigan<br>Philip Darvill | | Ongoing support throughout the project |
| Communications | Fiona Punchard | Ongoing | Communications supporting the development of all information leaflets and also the communicating of the Smoke Free Policy |
| Legal | TBC | | Legal team to support the Smoke Free Policy development |
| Kaizen Production Team | N/A | | |
| Trust Governors or Members | Have been involved as part of Quality Account development priority | Ongoing | Ongoing support throughout the project |
| Planning and Business Development | Phillip Darvill | Ongoing | Ongoing support throughout project |

| | | | |
|---|---|---|---|
| External Stakeholder (please list and add more rows if necessary) | Healthwatch, Overview and Scrutiny Committees & Clinical Commissioning Groups | Ongoing | These groups have been consulted as part of the Quality Account process to inform them of the Trusts plans and to receive their feedback on our plans |

## 8. Finance

There will be a significant increase in the cost of pharmacotherapies for those service users wishing to stop smoking. When SLaM went smoke free in October 2014 they estimated the cost of nicotine replacement therapies (NRT) to be approximately £120 per service user per year. However they recognised that the very heavy smokers used the electronic cigarette rather than NRT.

TEWVs Quality Account states that on average we have 778 patients occupying an inpatient bed each day which equates to an average occupancy rate of 88%. At 100% occupancy the Trust would have 880 beds. National data shows that there are approximately 48% of our patients who are smokers which indicates that 422 beds potentially could be occupied by a smoker each day.

NICE costs for a 12 week course of nicotine replacement therapies is £130.35 per patient. Clearly there are significant variables which will affect the final costings per year, such as:

- The average length of stay per patient- short or long stay
- The % who would use the electronic cigarette
- The % who would choose to go “cold turkey”
- The % who would use NRT for only a couple of weeks
- The % who would use NRT for the full 12 week course
- Repeat admissions may lead to more than one course of NRT per year

Significant numbers of our patients who are long stay will only ever use one full course of NRT which will significantly reduce the costings within these areas. In comparison other patients may require more than one course due to repeat admissions but may only use 14 days of NRT per admission.

Therefore an estimated cost would be:

422 x £130.35 (NRT) = £55,007.70 cost per year for NRT
211 x £130.35 (NRT) = £27,503.85 additional for repeat admissions

Total approximate costings: £82,511.55

Following the implementation of the smoke free agenda in March 2016 audit has been identified to provide accurate Pharmacy costings for NRT over Quarter 1 to Quarter 4 2016/17. This data can then be compared to previous costings for NRT within the Trust and provide a more accurate figure of NRT costings for future years.

As electronic cigarettes are currently unlicensed they would only be available for purchase by the service user meaning there would be no financial implication for the Trust. Service users will receive an individual assessment tailored to their needs and ultimately have the choice of which product to use during a quit attempt or for temporary abstinence.

Due to the increase in the essential blood tests required for Clozapine levels, once a patient goes smoke free, any potential cost saving in the reduction of drug dosage may be negated by the additional blood tests required.

Staff training costs would increase as part of the project as all clinical staff would be required to complete a 20 minute online training each year. In addition a more advanced training course will be available to selected staff on each ward with a yearly update.

South London & Maudsley NHS Foundation Trust has offered our Trust the opportunity to purchase an e-learning package which is specifically tailored to staff working in mental health care settings. This package can be tailored to each individual organisation, reflecting specific local policy. The package costs £5,000 and would be available for use by 5,000 staff. The Project Lead has been forwarded the link for the package to view and will review the content suitability for the Trust.

The development of Information Leaflets will cost approximately £200-£300 for an initial supply and following this the leaflet will be made available on the Trust site to download or to print copies for use. The cost of these leaflets will be absorbed within the current budget of the project as agreed at the PM1 Scoping stage.

There may be a one off cost for the removal of smoking shelters by estates and a potential cost to change the bike shelters into lockers as they are currently used by staff when smoking within the grounds. Further discussions with Estates are required to determine the exact Trustwide cost of this.

Signage may require updating or in fact developing to support the new smoke free initiative in order to re-inforce the smoke free message to service users, carers, visitors and staff to the Trust.

At this time the full exact costs of the elements of the project mentioned above are not known, therefore when the information on cost is made available a project change request form will be completed to request additional funding. The cost associated with the Project Managers post for the entirety of the project were requested and approved in December 2014 within the PM1 Project Scope document.

### 8.1. Finance and Quality Impact Assessment and CAPEX implications

Not applicable for this project.

## 9. Equality Analysis

The Equality Analysis is attached below. There were no identified negative impacts for any of the protected characteristic groups however the Trust is currently seeking legal advice in relation to smokers who are detained under the MHA and also their human rights.

Ultimately the revised Smoke Free Policy will benefit all identified groups providing a reduction in exposure to second hand smoke and lead to an improvement in both short and long term health.

We will provide treatment to smokers who wish to quit and support smokers who do not want to quit but wish to temporarily abstain from smoking whilst in Trust buildings or grounds. The treatment provided will be rigorous and tailored to specific needs, ensuring that the support required is identified within the care pathway from the point of entry to discharge. We will provide those who do not smoke with a healthy environment to work in and provide outside spaces that nurture wellbeing.

Identified service needs include the development of:

- generic service user leaflets,
- service user leaflets/videos for those with learning disabilities,
- visitor/carer leaflets,
- staff leaflets,
- Maternal leaflets for women and their partners.

All of the above smoke free leaflets should also be made available in large font and alternate languages as appropriate.


Equality Analysis Screening Form - Smc

Discussions are ongoing with the Trusts Equality and Diversity team to continuously develop the attached equality analysis to ensure that there is not any impact on equality of the Trusts staff, service users and carers.

## 10. Privacy Impact Assessment (PIA)/3rd Party Questionnaire

The Privacy Impact Assessment information will be developed as the project progresses.

## 11. Risks

| Description of risk | Identified by whom | Consequence if risk occurs (Negligible = 1 Minor =3 Moderate = 5 Major = 7 Catastrophic=9) | Likelihood (Rare = 1, Unlikely = 2, Possible=3, Likely = 4, Almost Certain = 5) | Total (conse-quence multiplied by likelihood) | Responsibility of whom | Countermeasures / Mitigation |
|---|---|---|---|---|---|---|
| Delivery of the project within the tight timeframe | Project Manager | 3 | 3 | 9 | Project Manager | The time frame for completion of this complex project was initially reduced from 12 months to 6 months. This has now been increased to 12 months again to support NTW who wish to work in partnership to implement the smoke free policy |
| Staff engagement with the smoke free policy | Project Manager | 3 | 3 | 9 | Project Manager | To establish staff “Survey Monkey” questionnaires and ensure all clinical staff complete the VBA training. Communication of the smoke free policy will support staff awareness and engagement along with the availability of information leaflets related to the smoke free agenda and support available. |

| | | | | | | |
|---|---|---|---|---|---|---|
| Service users engagement with the smoke free policy | Project Manager | 3 | 3 | 9 | Project Manager | We will carry out service user Patient & Public events (PPI) and will also provide:<br>• Information leaflets and videos<br>• Pharmacotherapies on admission to hospital<br>• Assessment and intensive behavioural support<br>• Electronic Cigarettes for sale |
| Support from senior management | Project Manager | 5 | 2 | 10 | Project Manager | Appropriate clinical and managerial leads will be identified for each Directorate. Regular updating for senior management is required to ensure the project is implemented in the agreed timeframe. |
| Increased financial costs linked to both the pharmacy budget and the training costs | Project Manager | 3 | 4 | 12 | Project Manager | NRT is seen as one of the most cost effective ways to save lives. SLaM identified a reduction in costs associated with antibiotic prescribing that was directly attributed to the smoke free policy, leading |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | to a dramatic reduction in chest infections. This led to a reduction by 50% of referrals to the GP for chest infections.<br>Training of staff will support service users to stop smoking and so is seen as an invaluable element of the smoke free agenda. |
| Project not delivered on time due to joint working with NTW | Project Manager | 3 | 3 | 9 | Project Manager | Key points to consider:<br>• Initial meetings with NTW lead to discuss the project development<br>• Identify Project Plan timeframes ASAP<br>• Ensure timeframes are adhered to<br>• Complete PM2 for directors on a monthly basis to identify any concerns at the earliest opportunity |

## 12. Project Plan

The detailed project plan can be reviewed by clicking on the embedded document below:

Detailed project plan - FINAL

## 13. Governance & Reporting

| Group/Forum | Members | Role | Frequency |
|---|---|---|---|
| EMT | • All members of EMT | Approve the project updates | When required |
| Smoking Cessation & Harm Reduction Group / Project Board | • Medical Director<br>• Clinical Director<br>• Planning & Business Development Manager<br>• Project Manager<br>• Modern Matrons<br>• Communications Lead<br>• FRESH representative<br>• Chief Pharmacist<br>• HR representative<br>• Public Health England representative | Govern the changes and support the key decisions | Monthly |
| Project Sub-Groups (x6) | • Project Lead<br>• Planning & Business manager<br>• Modern Matrons<br>• Staff side representatives<br>• FRESH manager<br>• HR representative<br>• Pharmacy Lead<br>• Communications<br>• Lead<br>• Medic representation<br>• Estates<br>• Information/risk and | Support the Project Plan development | Monthly as a minimum |

## 13. Stakeholder Analysis and Involvement

External stakeholders include smoking cessation services will be engaged when considering the scoping of existing practices and how they can support the implementation of smoking cessation.

| Stakeholder Group | Perceived Benefits or Loss for Group | Changes Needed | Power/ Importance of Stakeholder (High/ Medium/ Low) | Action | Timescale | Lead |
|---|---|---|---|---|---|---|
| **Internal** | | | | | | |
| Service Users | Service users will experience an improvement in both their short term and long term health which ultimately will lead to the narrowing of the gap in life expectancy | • Train all clinical staff in VBA<br>• Identify clinical staff to become Level 2 assessors<br>• Make available appropriate pharmacotherapies inclusive of e-cigarettes<br>• Adjust drug dosages as appropriate<br>• Provide intensive behavioural support<br>• Provide information leaflets/videos to support the smoke free agenda<br>• Develop pathways to support admission to hospital, care whilst in hospital and discharge to community stop smoking services<br>• Update the Smoke Free policy to support the project plan<br>• Communicate and implement the smoke free policy in the agreed timeframe | High Power | Resistance may come from the high percentage of service users who smoke within the mental health sector.<br><br>Previously service users have been given misleading and incorrect information regarding their mental health following smoking cessation which may lead to concern regarding becoming smoke free.<br><br>Training of staff will support appropriate information given and prompt offer of treatment. | April 2015 - March 2016 | Project Manager |

| | | | | | | |
|---|---|---|---|---|---|---|
| Staff | Staff will benefit from the reduced exposure to second hand smoke and the support available to stop smoking | • Provide stop smoking support for staff within the hospital setting including intensive behavioural support<br>• Allow staff 4 hours of support over the course of a stop smoking programme to enable them to become smoke free<br>• Make available for sale NRT within the hospital pharmacy<br>• Provide information leaflets detailing the support available and appropriate pharmacotherapies<br>• Offer and provide support for staff to remain smoke free during working hours -harm reduction approach<br>• Develop an online information site to support staff in both assessing service users and accessing personal smoking cessation support and information | High Power | Mental Health staff members have previously shown resistance to support service users to stop smoking, believing that service users are unable to stop and that it would in fact be detrimental to their mental health. This has shown in continued resistance to support the smoke free agenda. Regular communication required for staff detailing benefits to health over the course of the project | April 2015 - March 2016 | Project Manager |
| Visitors and Carers | Visitors and carers will benefit from the reduced exposure to second hand smoke and the support available to stop smoking | • Provide information leaflets for visitors and carers accessing the Trust detailing services available within the local area<br>• Make available for sale NRT within the hospital pharmacy<br>• Advise them not to smoke near the patient including in their home<br>• Provide an online information site linked to smoking and cessation which is accessible by visitors and carers | Medium Power | Visitors and carers can often be seen smoking within hospital grounds and may be resistant to change. They too may believe that their relative is unable to stop smoking and that it may be detrimental to their mental health Ensure provision of relevant information throughout the Trust | April 2015 - March 2016 | Project Manager |

| | | | | | | |
|---|---|---|---|---|---|---|
| **External** | | | | | | |
| Community Smoking Cessation Services | Community stop smoking services will benefit from the partnership working which will support both service users and staff to stop smoking.<br>This will potentially lead to achieving the ultimate goal of reducing the inequalities within Mental Health linked to smoking. | • Engage smoking cessation services to support the smoke free agenda<br>• Scope all existing practices<br>• Identify appropriate training packages available to the Trust<br>• Look at the potential for the provision of hospital on-site staff stop smoking clinics where appropriate | Medium Power | Community stop smoking services may fail to engage with the Trust should there be no reciprocal reward for training delivered i.e. Staff and service user data made available for DOH return via the Quit Manager system. Arrange regular meetings and updates for smoking service managers and trainers | April 2015-March 2016 | Project Manager |
| Local Alliances and Commissioners | Local Alliances and Commissioners will benefit from the reduction in smoking for service users and staff, potentially leading to the improved health and wellbeing of the local communities. | • Engage Local Alliances and Commissioners to support the smoke free agenda<br>• Identify appropriate staff to support the sub-groups linked to commissioning<br>• Continue to strengthen links with partner agencies | Medium Power | Provide relevant information for Commissioners and Alliances related to the smoke free implementation of the NICE PH 48 guidance | April 2015-March 2016 | Project Manager |

| | | | | | | |
|---|---|---|---|---|---|---|
| Lloyds Pharmacy services across TEWV | The potential for Lloyds Pharmacy to be commissioned to deliver on site stop smoking services to staff across TEWV | • Engage Lloyds pharmacy in discussion regarding the potential to be commissioned by Public Health to deliver on site staff stop smoking support<br>• Link with the community stop smoking services to deliver appropriate Level 2 training to Pharmacy staff | Low Power | Staff may fail to engage with the Pharmacy stop smoking services leading to the discontinuation of the Pharmacy services Ensure comprehensive advertising of Pharmacy services for staff | April 2015-March 2016 | Project Manager |

## 14. Proposed end of project close down / hand over arrangements

| Development Milestone | Month/Year | Resource |
|---|---|---|
| Business Case submitted for approval | June 2015 | Project manager / sponsor |
| Develop communications plan | June 2015 | Project manager / communications |
| Identification of available pharmacological options | June 2015 | Project manager / pharmacy |
| Stoptober | September 2015 | Project manager / project board |
| Complete and analyse staff surveys | December 2015 | Project manager |
| Review and update Trusts no smoking policy | December 2015 | Project manager / policy sub-group |
| Completion of staff training | March 2016 | Project manager / training sub-group |
| Complete project closure | March / April 2016 | Project manager / sponsor |

**Appendix 1 – progress to date**

A Project Manager for the Nicotine Management and Smoking Cessation Project commenced in post on 23 March 2015. In addition to the already established project board, six sub-groups have been identified which encompass the 16 NICE smoking cessation recommendations. Group members have been identified to support these groups from a variety of services allowing Trustwide representation.

A communication plan is being developed to regularly inform staff and service users of the plans to implement a policy on Nicotine Management and Smoking Cessation. This communications plan will aim to provide information on the smoking cessation support available to staff within the Trust, training information for staff to access in order to support service users wishing to become smoke free and also details of significant milestones throughout the course of the project such as the confirmed date to go smoke free.

Initial meetings have taken place with three external training providers, North Tees & Hartlepool Stop Smoking Service, Durham & Darlington Stop Smoking Service and North Yorkshire NHS Stop Smoking Service. The three external training providers will provide a Level 2 advanced training package which will allow staff to complete a comprehensive assessment for all service users wishing to stop smoking or undertake a harm reduction approach. Level 2 staff training is already underway in identified areas of Forensic services in Teesside and Durham & Darlington locations and future training will be available within all other areas of the Trust. Modern Matrons have been contacted to provide details of three staff within each ward area who would be identified to become a Level 2 trained assessor.

NICE guidance recommends that as a minimum Very Brief Advice (VBA) training is a mandatory yearly requirement for staff and so work is on-going to support this. This online training supports staff to identify a smoker, advise them of the appropriate support available and refer to appropriate services. The VBA online training is already being accessed within the Forensic Mental Health (FMH) and Forensic Learning Disability (FLD) services and should be completed for all forensics staff by 30 June 2015. All other areas across the Trust now also have access to this training with the aim that all service users who smoke will be identified upon admission and offered intensive support and pharmacotherapies as soon after admission as possible. All clinical staff will be required to complete the VBA training by 1 March 2016. The future aim will be to make the VBA training a mandatory or yearly requirement for all clinical staff from April 2016 and work is underway to achieve this with the Medical Director supporting this action and will submit the proposal to the Executive Management Team (EMT) for final decision and approval. An audit will be carried out post March 2016 to ascertain the impact of the VBA training on the identification of a smoker and support given to them following the smoke free implementation throughout the Trust.

Initial Pharmacy meetings have taken place to look at the pharmacotherapies currently available for use and also to look at the potential use of Varenicline and Bupropion within mental health settings. Varenicline and Bupropion have previously not been included in TEWV “guidance on the use of stop smoking products” due to Bupropion being contraindicated for use and Varenicline being linked to depression and suicidal ideation. A decision has been taken to re-look at current evidence to

reassess if either product could be introduced within the Trust. The South London & Maudsley NHS Foundation Trust (SLaM) now use Varenicline as a first line product for schizophrenia in stable service users only and therefore TEWVs Chief Pharmacist will be leading on the decisions to be made regarding suitability.

Information sheets are under development within the pharmacy team which will support staff in identifying the specific drugs with the potential to interact during smoking/smoking cessation (Clozapine, Olanzapine amongst others). The information sheets once completed will be submitted for approval to the Drugs and Therapeutic Committee and presented at EMT for final approval. The NHS United Kingdom Medicines Information (UKMI) document and SLaM supporting information will also be available along with pathways for use.

The Smoke free Mental Health Trusts event on "Tackling the burden of smoking in mental health settings" took place on 30 April 2015 where 60 places were made available to TEWV Trust staff members who attended. Other Trusts attending were Northumberland, Tyne & Wear (NTW), Lancashire NHS Foundation Trust and Royal Devon & Exeter. Throughout the event discussions took place regarding the 16 recommendations identified by the NICE PH48 guidance and outcomes of the discussions will support the development and implementation of this guidance. This event proved extremely productive and ongoing discussions are taking place with NTW to support the implementation of the Trusts plan to provide a smoke free environment.

Tobacco smoking remains the single greatest cause of preventable illness and premature death in England and smoking prevalence is particularly high among people with mental health problems. Treating smoking related illnesses in people with mental health problems has been estimated to cost the NHS an estimated £720 million a year in primary and secondary care. Given that smoking can reduce their effect, smoking increases psychotropic drug costs in the UK by up to £40 million (Royal College of Physicians 2013). It is therefore imperative that as a Trust we look at the available, alternative treatments in order to reduce the risks to patient's health and lead to an increase in their life expectancy.

One of the main alternatives being considered by the Trust is the electronic cigarette (e-cigarette). Potentially the e-cigarette is considered to be a far less harmful option than continuing to smoke. In the view of Public Health England it is never better for a smoker or those around them to smoke rather than vape (smoke with an e-cigarette). Although not completely without risk, experts estimate[1] that electronic cigarettes carry 95% less risk than smoking.

With this in mind there are discussions taking place regarding the options available as they are currently an unlicensed product. If the decision is taken to implement them as the preferred alternative to cigarettes there would be no cost to the Trust as the service user would purchase them as with cigarettes. Once licensed in the future, discussion would need to take place regarding the potential prescribing of these products and any cost implications due to the fact that as a licensed product they will be classed as a medicine and therefore made available within the hospital pharmacy as with other nicotine replacement products. Currently a service user stopping

[1] *Estimating the harms of Nicotine-Containing Products Using the MCDA Approach*, (Nutt et al, 2014)

smoking that was prescribed a nicotine patch and a nicotine inhalator would cost the Trust approximately £25 per week for the supply vs. £0 for the e-cigarette. It is never the less crucial that we provide all available options for the service users to choose that which is the most appropriate option so that they can make individual choices as to their preferred product.

Further discussion is required regarding the potential for staff to use e-cigarettes but the current consensus amongst the majority of staff seems to be not to allow their use by staff during working hours, as currently some staff are seen openly using them in front of service users within the ward environment or offices. Staff use of the e-cigarette may prompt service users, who are non-smokers, to try the e-cigarette. Staff are regarded as advocates for health and may be seen as role models.

NICE guidance recommends that on-site stop smoking services for staff should be available and options are currently being considered for assessment and supply of pharmacotherapies by Occupational Health services, Pharmacy services, extended prescribers or local community stop smoking services to deliver within the hospital setting. NICE guidance also recommends that a range of nicotine replacement products are made available for sale in all hospital site pharmacies for staff, visitors and carers. Meetings have taken place with the Trusts Chief Pharmacist to review the options available to the Trust taking into account its vast geography and variations in location type's e.g. main hospital facilities such as West Park in comparison to community team bases such as the Goodall Centre.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

# Equality Analysis Screening Form

| | | | | | | |
|---|---|---|---|---|---|---|
| **Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc** | Nicotine Management and Smoking Cessation Project | | | | | |
| | | | | | | |
| **Name of working party, to include any other individuals, agencies or groups involved in this analysis** | Nicotine Management and Smoking Cessation Project Board<br>6 x sub-groups as identified within NICE guidance | | | | | |
| **Title** | Nicotine Management and Smoking Cessation Project | | | | | |
| **Is the area being assessed a** | **Policy/Strategy** | | **Service/Business plan** | **X** | **Project** | **X** |
| | **Procedure/Guidance** | | | | **Code of practice** | |
| | **Other – Please state** | | | | | |
| **Geographical area** | TEWV Trust wide all areas | | | | | |
| **Aims and objectives** | To implement the project as defined within the Business Case PM3 document and achieve the priority actions detailed within the Trusts 2015-18 Business Plan and 2014/15 Quality Account. | | | | | |
| **Start date of Equality Analysis Screening** | 28th April 2015 | | | | | |
| **End date of Equality Analysis Screening** | Ongoing | | | | | |

## Please read the Equality Analysis Procedure for further information

You must contact the E&D team if you identify a negative impact. If you require further advice and support please ring Sarah Jay or Tracey Loynes on 0191 3336267/3542

| | | | | | |
|---|---|---|---|---|---|
| **1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?** | | | | | |
| The project benefits all service users, visitors, carers, relatives and staff employed by the Trust or contractors carrying out work on Trust premises. | | | | | |
| **2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?** | | | | | |
| **Race** (including Gypsy and Traveller) | No | **Disability** (includes physical and mental impairment) | No | **Gender** (Men and women) | No |
| **Gender reassignment** (Transgender and gender identity) | No | **Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual) | No | **Age** (includes, young people, older people – people of all ages) | No |
| **Religion or Belief** (includes faith groups, atheism and some other non religious beliefs) | No | **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) | No | **Marriage and Civil Partnership** (includes opposite sex and same sex couples who are either married or civil partners) | No |
| **Yes – Please describe the anticipated negative impact** None<br>**No – Please describe any positive outcomes**<br><br>The project will benefit the health and wellbeing of all identified groups. The implementation of the project will provide a completely smoke free environment which ultimately will lead to a reduction in exposure to second hand smoke thereby leading to an improvement in both short term and long term health. The Trust will ensure that the smoking cessation assessment and treatment offered is rigorous, suited and tailored to individual specific needs, ensuring that the support required is attained within the care | | | | | |

pathway from the point of entry to discharge.

By implementing the smoke free project the Trust will be ensuring that under 18s are prevented from smoking in the Trust and will also reduce the risks to health by exposure to second hand smoke.

Pregnant women and their partners will see a positive impact on their unborn child linked to the reduced exposure to the toxins within a cigarette. The smoke free project will also see a reduction in second hand smoke and address the potential risks this may cause to the foetus such as miscarriage and low birth weight.

Due to the potential for an increase in weight whilst stopping smoking, links have been developed with the Physical Health Lead to provide appropriate dietary information along with information related to physical exercise and general health and wellbeing.

The identification of appropriate volunteers will also support service users from the above groups who may need additional advice and support whilst stopping smoking.

| | | | | |
|---|---|---|---|---|
| **3.** Have you considered any codes of practice, guidance, project or business plan benefit? **If 'No', why not?** | **Yes** | **X** | **No** | |

**Sources of Information may include:**

- Feedback from equality bodies, e.g. Care Quality Commission, Disability Rights Commission, etc
- Investigation findings
- Trust Strategic Direction
- Data collection/Analysis
- Staff grievances
- Media
- Community Consultation/Consultation Groups
- Internal Consultation
- Other (Please state below)

All of the above have been taken into consideration whilst developing the project objectives and the completion of the Business Case.

| **4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership** |
|---|
| **Yes – Please describe the engagement and involvement that has taken place**<br>Open discussions have taken place with staff within multiple meetings throughout TEWV. These meetings include the Smoking Cessation Steering Group, Sub-Group meetings and JCC meeting. An overview of the Project Plan was given followed by a Q&A session where staff were able to identify any concerns or benefits related to both staff and service users. |
| **No – Please describe future plans that you may have to engage and involve people from different groups**<br>Events are planned across all service user groups to look at the impact of the smoke free agenda on both smokers and non-smokers.<br>Survey Monkey questionnaires will take place for staff to enable them to discuss the impact of the smoke free agenda for both smokers and non-smokers.<br>Public and Patient Involvement (PPI) events are planned within the next few months to ensure service users are able to voice any concerns or positive thoughts they may have regarding the smoke free agenda.<br>In conjunction with the Communications Team we will be providing regular updates for staff linked to the project Plan and identified goals for the future-This will enable staff to offer up to date information to all service users and visitors to the Trust. |

| **5. As part of this equality analysis have any training needs/service needs been identified?** | |
|---|---|
| Yes | It is proposed that all staff are trained yearly in the 'Very Brief Advice' (VBA) online training tool with additional staff taking on the responsibility of further level 2 training – further information can be found within the detailed Business Case. |

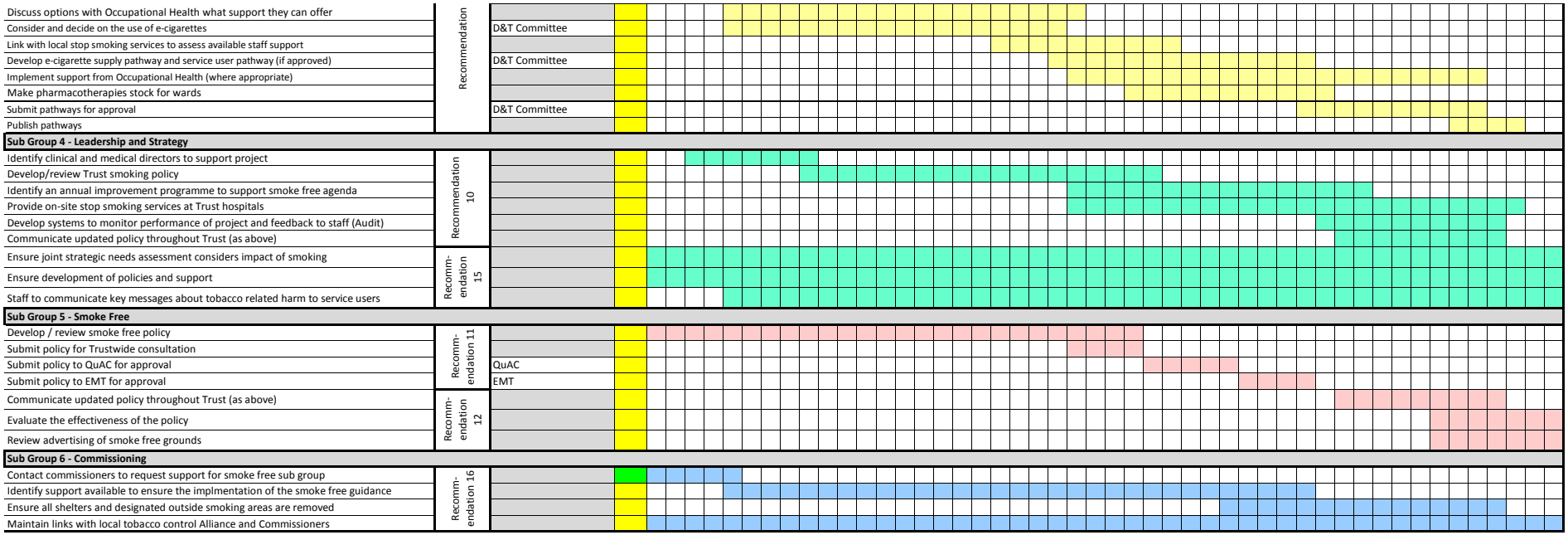
| **A training need has been identified for** | | | | | |
|---|---|---|---|---|---|
| <u>Trust staff</u><br>All Clinical Trust staff will have access to information leaflets detailing the smoke free agenda and services available to those | Yes | <u>Service users</u><br>The Trust will develop and make available information leaflets and if appropriate videos to support those | Yes | <u>Contractors or other outside agencies</u><br>Information leaflets will be developed and made available to all contractors or | Yes |

| | | | | | |
|---|---|---|---|---|---|
| who currently smoke and wish to stop | | service users identified below in relation to supporting the understanding of the smoke free agenda<br>• Learning Disability<br>• Pregnant and breastfeeding women and their partners<br>• Age- both young and older persons<br>• Poor vision and hearing | | outside agencies to ensure they comply with the smoke free policy at all times and are given the details of local services available to them should they wish to access stop smoking services | |

**Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so**

| | |
|---|---|
| The completed EA has been signed off by:<br>You the Policy owner/manager:<br>Type name: LESLEY COLLEY | Date:<br>05/06/2015 |
| Your reporting manager:<br>Type name: CLAIRE CUTHBERTSON | Date:<br>05/06/2015 |
| Please forward this form by email to: tewv.policies@nhs.net<br>**Please Telephone: 0191 3336267/6542 for further advice and information on equality analysis** | |

| MED 13.02 Nicotine Management and Smoking Cessation project plan | NICE Recomm-endation | Governance | Status | May-15 | | | | Jun-15 | | | | | Jul-15 | | | | Aug-15 | | | | | Sep-15 | | | | Oct-15 | | | | | Nov-15 | | | | | Dec-15 | | | | | Jan-16 | | | | Feb-16 | | | | | Mar-16 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Activity** | | | | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 |
| **Governance Groups** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Project Board (inc. sub group 4) | | | | | | | | | 11 | | | | | 9 | | | | | 13 | | | | | 10 | | | | | 8 | | | | 12 | | | | | 1 | | | | | | | | | | | | | | |
| Set up subgroups | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sub group 1 - Provision of information and training | 1, 5 & 14 | | | | | | | 3 | | | | | 1 | | | | 5 | | | | | 2 | | | | 7 | | | | 3 | | | | 2 | | | | | | | | | | | | | | | | | |
| Sub Group 2 - Identification of smokers and provision of support to them (dates TBC) | 2, 3, 4, 6, 9 & 13 | Project Board | | | | | | 3 | | | | | 1 | | | | 5 | | | | | 2 | | | | 7 | | | | 3 | | | | 2 | | | | | | | | | | | | | | | | | |
| Sub Group 3 - Pharmacies | 7 & 8 | | | | | | | | 9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sub Group 5 - Smoke free | 11 & 12 | | | | | | | | | | | | 2 | | | 29 | | | | 26 | | | | | 30 | | | | 28 | | | | 25 | | | | | | | | | | | | | | | | | | | |
| Sub Group 6 - Commissioning | 16 | | | | | | | | | | | | 2 | | | 29 | | | | 26 | | | | | 30 | | | | 28 | | | | 25 | | | | | | | | | | | | | | | | | | | |
| Develop Project Closure documentation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Submit Project Closure documentation for approval | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Sub Group 1 - Provision of Information and Training** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Set up monthly meetings with the Communications Team | NICE Recommendations 1 & 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Identify budget for printing of leaflets | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Develop Communications plan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Invite service users and carers to leaflet development sessions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Develop TEWV information leaflets/sheets for service users | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Develop TEWV information leaflets/sheets for relatives, carers, friends and visitors | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Identify appropriate NHS leaflets to be made available throughout Trust | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Identify any changes to Trust letterhead identifying Trust as smoke free | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Submit information leaflets / sheets for approval | | Virtual service user and carer group, Acute Care Forum, QuAG | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Smoke free Trust new identity/letterhead included in all correspondence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Once approved send for printing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Plan process for making all information available Trustwide | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Publish leaflets on Trust website | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Identify appropriate training packages | Recommendation 14 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Identify appropriate trainers to deliver the training sessions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| All clinical staff trained on Very Brief Advice (VBA) online training | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ward managers identify min 3 staff to become Level 2 Assessor for smoking cessation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| All staff aware of where and how to refer | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| All staff to be provided with information about the smoke free policy and instructions about their roles and responsibilities in maintaining a smoke free environment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| VBA to be included as a mandatory or yearly training session | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Sub Group 2 - Identification of smokers and provision of support to them** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Inclusion of smoking question in Trust FFT | Recommendation 2, 3 & 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FFT take place and analyse by 1st Aug | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ensure all clinical staff have completed VBA training (as above) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Develop on site support services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Identify and complete Level 2 Assessor training for smoking cessation (as above) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Develop staff survey | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Adjust drug dosages as indicated (as below) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conduct staff survey on proposed smoke free agenda | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Complete analysis from surveys reporting back to Project Board on findings | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Develop 2nd staff survey | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conduct 2nd staff survey on future service development for staff and feedback to board | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Offer and supply pharmactherapies (as below) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Communicate policy and offer support (as above) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Identify ward stock of nicotine replacement | Recomm-endation 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Identify if e-cigarette is to be available for use by service users | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Review potential supplier for e-cigarettes and develop plan for access and delivery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Inpatient pathways to be developed | Recomm-endation 9 | D&T Committee | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Develop discharge pathways for discharge to community | | D&T Committee | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ensure systems are in place to record smoking status (PARIS) | | Paris Programme | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provide advice for staff who smoke on how to stop (as above) | Recomm-endation 13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Identify services available for staff to access in-house stop smoking support | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Consult Lloyds to offer staff and visitors stop smoking service | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Review potential for Trust hospital pharmacies to sell NRT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Sub Group 3 - Pharmacies** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Develop information sheets to support drug dosage adjustments and pathways | Recomm-endation 7 | D&T Committee | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Submit for approval information sheets, nicotine management guidelines and pathways | | D&T Committee | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Delivery medical staff training | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Publish information sheets | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Review range of pharmacotherapies available | 8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Liaise with Lloyds to review available options for sale to staff and visitors | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Review possibility wards containing a stock of nicotine products | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |


Discuss options with Occupational Health what support they can offer
Consider and decide on the use of e-cigarettes
Link with local stop smoking services to assess available staff support
Develop e-cigarette supply pathway and service user pathway (if approved)
Implement support from Occupational Health (where appropriate)
Make pharmacotherapies stock for wards
Submit pathways for approval
Publish pathways
Recommendation
D&T Committee
D&T Committee
D&T Committee
Sub Group 4 - Leadership and Strategy
Identify clinical and medical directors to support project
Develop/review Trust smoking policy
Identify an annual improvement programme to support smoke free agenda
Provide on-site stop smoking services at Trust hospitals
Develop systems to monitor performance of project and feedback to staff (Audit)
Communicate updated policy throughout Trust (as above)
Recommendation 10
Ensure joint strategic needs assessment considers impact of smoking
Ensure development of policies and support
Staff to communicate key messages about tobacco related harm to service users
Recomm-endation 15
Sub Group 5 - Smoke Free
Develop / review smoke free policy
Submit policy for Trustwide consultation
Submit policy to QuAC for approval
Submit policy to EMT for approval
Recomm-endation 11
QuAC
EMT
Communicate updated policy throughout Trust (as above)
Evaluate the effectiveness of the policy
Review advertising of smoke free grounds
Recomm-endation 12
Sub Group 6 - Commissioning
Contact commissioners to request support for smoke free sub group
Identify support available to ensure the implmentation of the smoke free guidance
Ensure all shelters and designated outside smoking areas are removed
Maintain links with local tobacco control Alliance and Commissioners
Recomm-endation 16

**BOARD OF DIRECTORS** **ITEM 12**

**Date of Meeting:** **July 23rd 2015**

**Title:** **Review of Strategic Goals 'This Means That Statements'**

**Lead Director:** **Sharon Pickering, Director of Planning, Performance and Communications**

**Report for:** **Consultation**

## This report includes/supports the following areas:

| **STRATEGIC GOALS:** | ✓ |
|---|---|
| **To provide excellent services working with the individual users of our services and their carers to promote recovery and well being** | |
| **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 our communities** | ✓ |
| **To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities** | ✓ |

| **CQC REGISTRATION: Outcomes (✓)** | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | | Staffing | | Supporting workers | |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | ✓ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

**BOARD OF DIRECTORS**

**Date of Meeting:** **23rd July 2015**

**Title:** **Review of Strategic Goals 'This Means That Statements'**

## 1. INTRODUCTION & PURPOSE

1.1 The purpose of this report is to seek the Board of Directors' approval for proposed revisions to the Trust's This Means That Statements.

## 2. BACKGROUND INFORMATION

2.1 The This Means That Statements (TMT Statements) were introduced into TEWV when the organisation determined its Strategic Goals in 2008/9.

2.2 Their original purpose was to be a way of communicating the Strategic Goals in a meaningful way to service users, staff and stakeholders. They were originally designed to describe what people would experience/see/feel if we were delivering the strategic goal

2.3 Over the past few years, the TMT Statements have tended to be used solely as a tool within the 2 day October Business Planning workshop. As a result they have increased in numbers and complexity and as they currently stand are not a useful communication tool for explaining the strategic goals to our staff and stakeholders.

2.4 A revision is therefore required so that they can regain their role as a useful communication tool that explains what it would be like if we were achieving the Strategic Goals in simple, everyday language.

## 3. KEY ISSUES:

3.1 The current TMT statements are set out in **Appendix 1**. They are a mix of aspirations, standards and statements. There are 57 TMT Statements in total

3.2 The final proposals that take the proposals from staff into account are set out in **Appendix 2**.

3.3 On June 17th, when EMT agreed that the proposed changes should be submitted to the Trust Board for approval subject, it also agreed that the views of the Trust's staff should be sought. E-bulletin was used to give staff the opportunity to put forward suggested changes. 4 replies were received. A summary of these is set out in **Appendix 3**, with the one proposed resulting addition to the statements highlighted in yellow within Appendix 2.

## 4. IMPLICATIONS / RISKS:

4.1 There are no significant risks associated with making the proposed changes to the This Means That statements.

## 5. CONCLUSIONS

The TMT Statements have changed over the last few years and become a mix of standards/aspirations and statements. In doing so they have lost their original function as a communications tool in terms of what our Strategic Goals mean. It is vital that our staff and stakeholders understand what the strategic goals mean in practice and the revisions proposed in Appendix 2 are designed to achieve this.

## 6. RECOMMENDATIONS

Trust Board are requested to approve the revised set of This Means That Statements set out in Appendix 2 of this report.

**Chris Lanigan**
**Head of Planning and Business Development**

**Background Papers: none**

# APPENDIX 1 – CURRENT TMT STATEMENTS

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

**This means that:**

a) We deliver safe and high quality services which improve the health and wellbeing of our users and their carers
b) We safeguard those at risk of harm.
c) Users of our services and their carers have positive experiences and outcomes.
d) Users of our services are seen when they need to be, at a time convenient to them, have no unnecessary transfers and no delays in starting treatment.
e) Users of our services are fully involved in the development and delivery of their care plan.
f) All of our estate is of high quality.
g) We continually seek and act upon feedback, from our service users and carers, on the services we provide
h) We provide high quality accessible information about our services and how people can access them.
i) We work with our service users and carers to enable them to achieve a their recovery goals.
j) We minimise harm occurring to the users of our services

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

**This means that:**

a) We continually improve patient safety throughout the organisation.
b) We are accredited and known locally, nationally and internationally for our high quality services and continuous improvement
c) The quality of our services is demonstrated through real time patient experience and outcome measures
d) The TEWV Quality Improvement System is embedded and aligned throughout the Trust to deliver continuous improvement in the quality, and value of our services
e) The Trust and its staff only do things that add value to our customers.
f) The Trust promotes a culture that encourages and enables staff to identify and eliminate waste.
.We deliver services that are evidence-based and clinically cost-effective.
g) We have an active programme of funded research and development to improve the services we provide.
h) We actively seek out and report good practice and successfully disseminate it throughout the organisation.
i) We promote a culture of actively challenging and reporting unsafe practice, quickly learning from our experience and embedding lessons learned.
j) We use high quality pathways of care to support standardised work and deliver consistently good outcomes.
k) The relevant information to improve services and optimise patient experience and outcomes is readily available to staff

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

**This Means That**

a) We continuously improve our staff survey results and are in the top 10% performing mental health trusts nationally.
b) Our staff feel supported and valued at work.
c) Our staff have well defined job roles which add value.
d) Our staff work both productively and flexibly and with compassion
e) We promote and support the wellbeing of our staff.
f) We engage all our staff through effective communication and involvement.
g) We proactively support clinical staff to be involved in the leadership and management of the Trust.
h) We consistently demonstrate behaviours consistent with the Trust's values
i) The Trust and its staff understand and follow the Trust Compact.
j) Our staff access appropriate education, training, development and leadership opportunities.
k) We provide high quality placements for students throughout the organisation
l) The Trust and its staff respect and embrace the Human Rights and diversity of our workforce, users and their carers
m) We have the right staff with the right skills, competencies and attitudes to provide excellent services that deliver our care pathways
n) We have effective workforce and succession planning in place
o) All of our staff understand the value of their Total Reward statement
p) We fully contribute to the effectiveness of Health Education North East (HENE).

**Strategic Goal 4:** *To have effective partnerships with local, national and international organisations for the benefit of the communities we serve.*

**This Means That**

a) We support our commissioners to effectively commission Mental Health, Learning Disability, Substance Misuse and other specialist services
b) We engage with NHS England locally, regionally and nationally
c) We work closely with all GPs in our area to ensure they can access our services appropriately and provide effective care for patients with mental health, learning disability or substance misuse needs
d) We in partnership with Local Authorities to support the delivery of a seamless service for our users and carers.
e) We influence and contribute to each Health and Wellbeing Board in the communities we serve
f) We are the partner of choice for the training of health and social care professionals
g) We have a range of formal and informal partnerships with providers and agencies across the public, private and voluntary sectors for the benefit of the communities we serve
h) We have a growing portfolio of funded research and development which we use to improve the quality of our services
i) We have effective working arrangements with every Acute Foundation Trust in our area
j) We have effective working arrangements with all elements of the criminal justice system

## Strategic Goal 5

*To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve*

**This Means That**

a) Our Council of Governors is fit for purpose and actively engaged in our strategic development.
b) We maintain the highest rating of regulatory compliance and maintain the level of transparency and candour required
c) We engage the membership of the Trust in the governance arrangements of the organisation
d) We regularly use benchmark and outcomes data to deliver improvements in quality and value
e) The Trust supports staff and services to improve productivity through use of the best available tools and technologies / methodologies
f) We reduce the impact of our business on the environment
g) We actively promote our successes to develop our reputation and brand to all stakeholders and are regarded as the provider of choice
h) We deliver a Trust Business Plan which is dynamic, flexible and responsive to the changing environment.
i) The Trust is rated in the top 10% for patient outcomes, experience and cost efficiency
j) The information we produce is accurate, timely and of high quality

# APPENDIX 2 – PROPOSALS FOR REVISED TMT STATEMENTS

## REVISED THIS MEANS THAT STATEMENTS

SG1: To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing

This means that we make a positive difference to the lives of service users and carers by:

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

SG2: To continuously improve to quality and value of our work

This means that we only do things that add value to our customers by:

- Constantly challenging ourselves to improve and learn from experience
- Promoting a culture and providing the tools that empower staff to improve quality and eliminate waste
- Always considering the impact on service users in the design of our processes and development of plans for change.[1]
- Having an active programme of applied research and development
- Actively responding to and learning from customer feedback
- Ensuring staff have access to accurate, timely and relevant information

SG3: To recruit, develop and retain a skilled, compassionate and motivated workforce

This means that we are an excellent employer by

- Promoting a culture where our staff feel engaged and valued
- Ensuring all our staff work in line with the Trust values, behaviours and compact
- Promoting and supporting the health and wellbeing of our staff
- Ensuring we have effective leadership and management throughout the organisation
- Providing appropriate education, training, development and leadership opportunities for all staff
- Providing high quality placements for student health care professionals and trainees as the future workforce

[1] This statement has been added to the version approved by EMT in response to a suggestion from a TEWV employee – see Appendix 3 below

SG4: To have effective partnerships with local, national and international organisations for the benefit of the communities we serve

This means that we work closely with our partners to improve the health and wellbeing of the people we serve by:

- Influencing the development of local and national strategies
- Supporting our commissioners to commission excellent and efficient services that meets the needs of the communities we serve
- Work closely with all GPs and other providers to support them in providing effective healthcare for patients with mental health or learning disability needs
- Working with local authorities to provide personalised services
- Proactively engaging with a wide range of stakeholders on the wider health and social care agenda

SG5: 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.

This means that we will be a successful and sustainable organisation by:

- Having effective governance arrangements
- Actively involving Governors and Members in the work of the Trust
- Having a business and financial planning process which is dynamic, flexible and responsive to the environment
- Investing in the technology, and facilities that our staff need to maximise productivity
- Ensuring we are the provider of choice of commissioners and the public
- Reducing our carbon footprint

## Appendix 3 – Suggestions from Staff in response to circulation of EMT Proposals

| Proposal (summary) | Director of PP&C response |
|---|---|
| Delete all of the "This means that…." introductory sentences and change the text of the Strategic Goals instead | Board have not indicated a desire to change the Strategic Goals and the opening "This means that…." sentences are intended to provide further explanation of the Strategic Goal. Therefore on balance we believe that this suggestion is not actioned. |
| Change GP related bullet in SG4 to use the vision statement for the Engaging with GPs as Partners in Care project instead | The TMT Statements are deliberately not written in "vision statement" type language but in more concrete practical language. The GP Engagement project can be supported by the proposed TMT Statement and vice versa without needing to change the text. |
| Put something in to show that we will always strive to put patients first – this would indicate that we recognise that one of the causes of Mid Staffs was the organisation seeing its own needs / corporate systems and processes as more important than patients' needs. | The Trust already recognises the importance of putting service users first, which is the first "behaviours" bullet in our Values. The TMT Statements in SG1 also emphasise the importance of effective service delivery. We also have the QIS emphasis on reducing non value adding activity, which implies that corporate systems will constantly be reviewed to ensure they are both necessary and streamlined. However, given the importance of this issue, we could add an additional TMT statement under SG2 – "Always considering the impact on service users in the design of our processes and development of plans for change." This implies that the impact on patient care of involving clinical staff in planning and improvement should always be carefully considered. This proposed change is highlighted in yellow in **Appendix 2**. |
| Add something to acknowledge the importance of monitoring and managing patients' physical health and wellbeing. | The existing THT Statements under Strategic Goal 1 are intended to refer to all aspects of patients' health and wellbeing including physical health, and so on balance we think that we should not include a specific TMT statement on physical health |

**ITEM 13**

**FOR GENERAL RELEASE**

**BOARD OF DIRECTORS**

**Date:** **23 July 2015**

**Title:** **Finance Report for Period 1 April 2015 to 30 June 2015**

**Lead Director:** **Colin Martin, Director of Finance**

**Report for:** **Assurance and Information**

## This report includes/supports the following areas:

| **STRATEGIC GOALS:** | ✓ |
|---|---|
| **To provide excellent services working with the individual users of our services and their carers to promote recovery and well being** | |
| **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 our communities** | |
| **To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities.** | ✓ |

| **CQC REGISTRATION: Outcomes (✓)** | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | | Staffing | | Supporting workers | |
| **Quality and management** | | | | | |
| Statement of purpose | ✓ | Assessing and monitoring quality of service provision | | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | ✓ |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | ✓ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

**BOARD OF DIRECTORS**

**Date of Meeting:** **23 July 2015**

**Title:** **Finance Report for period 1 April 2015 to 30 June 2015**

## 1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2015 to 30 June 2015.

## 2. BACKGROUND INFORMATION

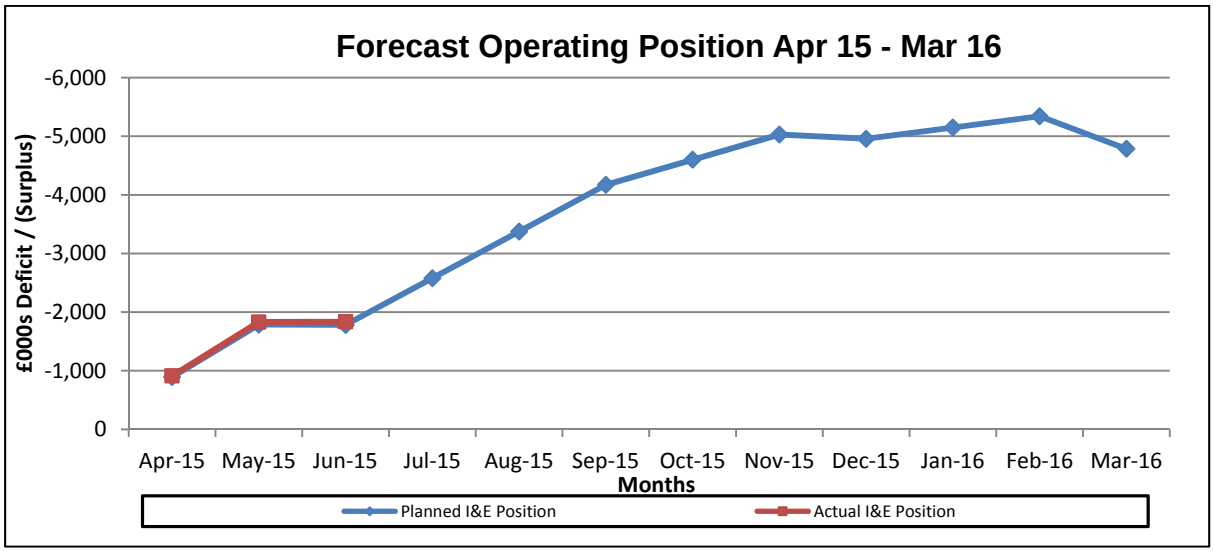
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

## 3. KEY ISSUES:

3.1 Statement of Comprehensive Income

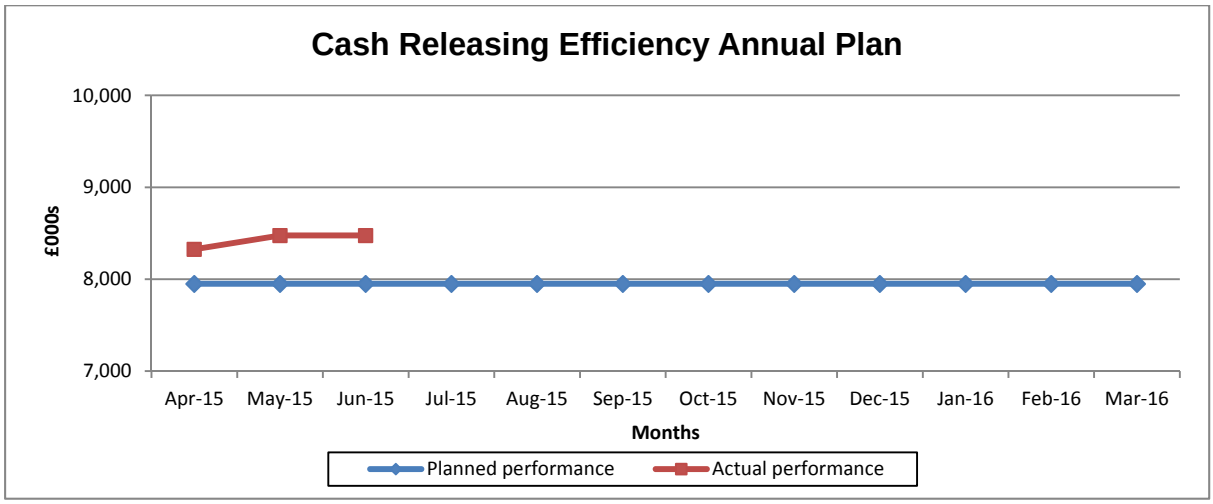
The financial position shows a surplus of £1,834k for the period 1 April 2015 to 30 June 2015, representing 2.5% of the Trust's turnover and is marginally ahead of plan.

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

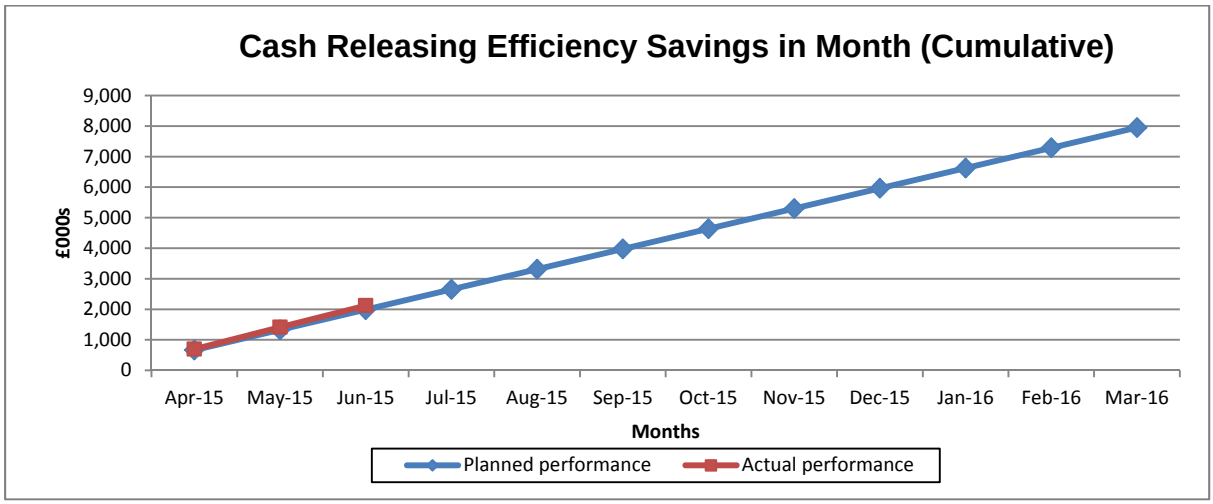


## 3.2 Cash Releasing Efficiency Savings

Total CRES identified at 30 June 2015 is £8,475k and is £526k ahead of plan.

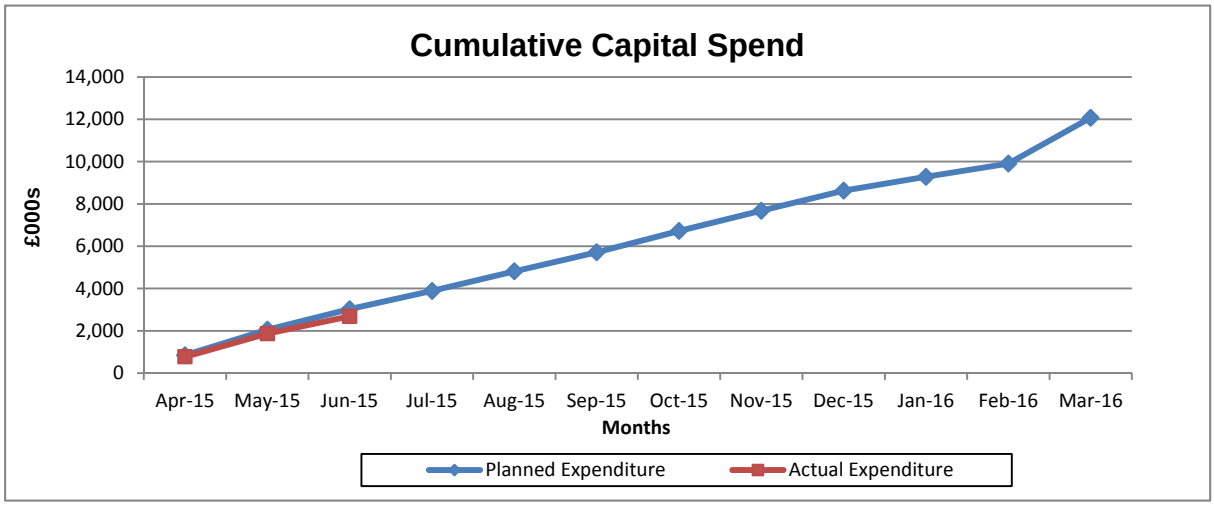



The monthly profile for CRES identified by Localities is shown below.



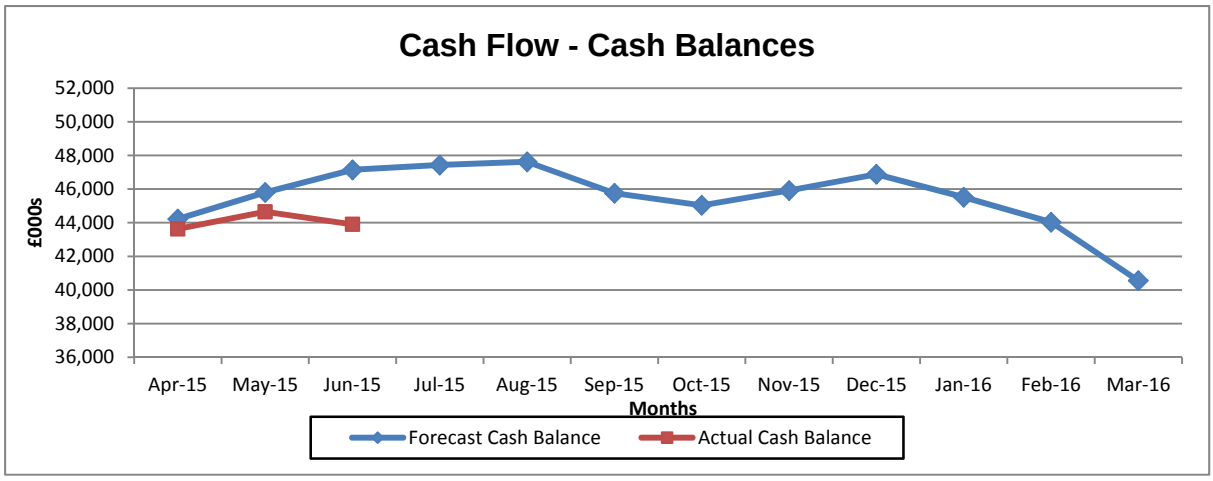

## 3.3 Capital Programme

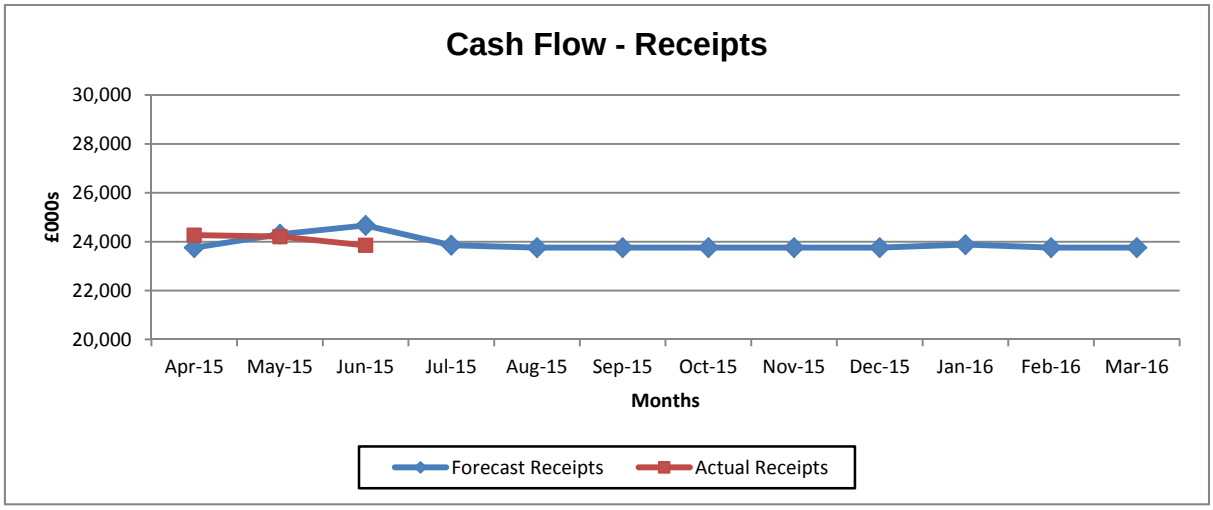
Capital expenditure to 30 June 2015 is £2,685k, which is marginally behind plan.

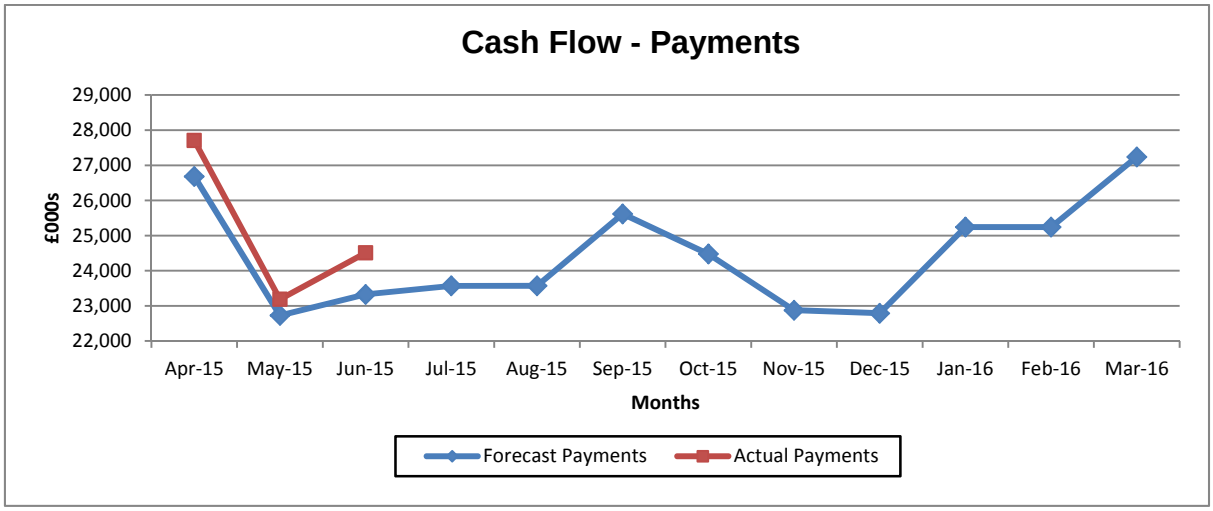


## 3.4 Cash Flow

Total cash at 30 June 2015 is £43,932k and is behind plan due to fluctuation in working capital, mainly within creditor payments and accrued income.



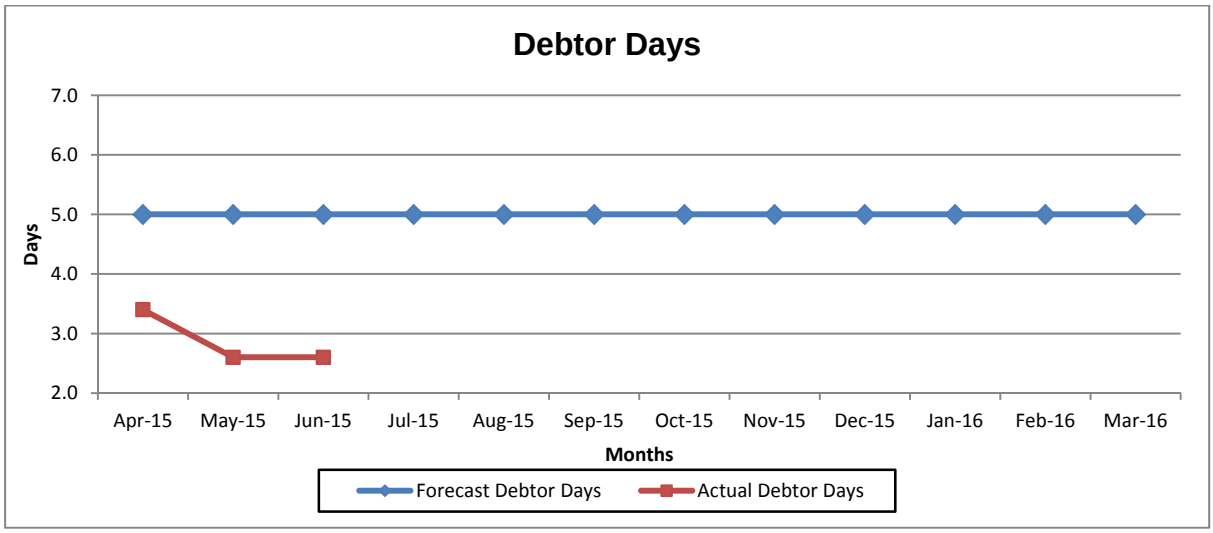




The payments profile fluctuates over the year for PDC dividend payments, financing repayments and payments for capital expenditure.

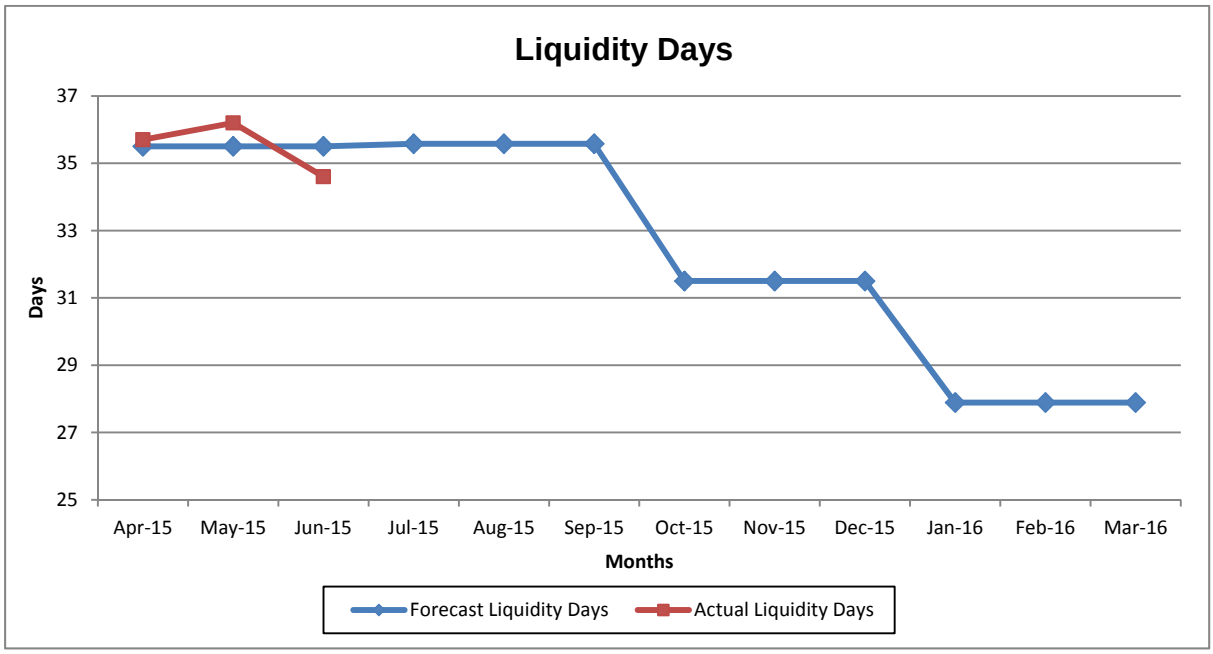
Working Capital ratios for period to 30 June 2015 were:

- Debtor Days of 2.6 days
- Liquidity of 34.6 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 83.07%
  Non NHS 30 Days – 98.22%




The Trust had a debtors' target of 5.0 days and actual performance of 2.6 days, which is ahead of plan.

3.4.1 The liquidity days graph below reflects the metric within Monitor's risk assessment framework. The Trust liquidity day's ratio is marginally behind plan, but is not a cause for concern.



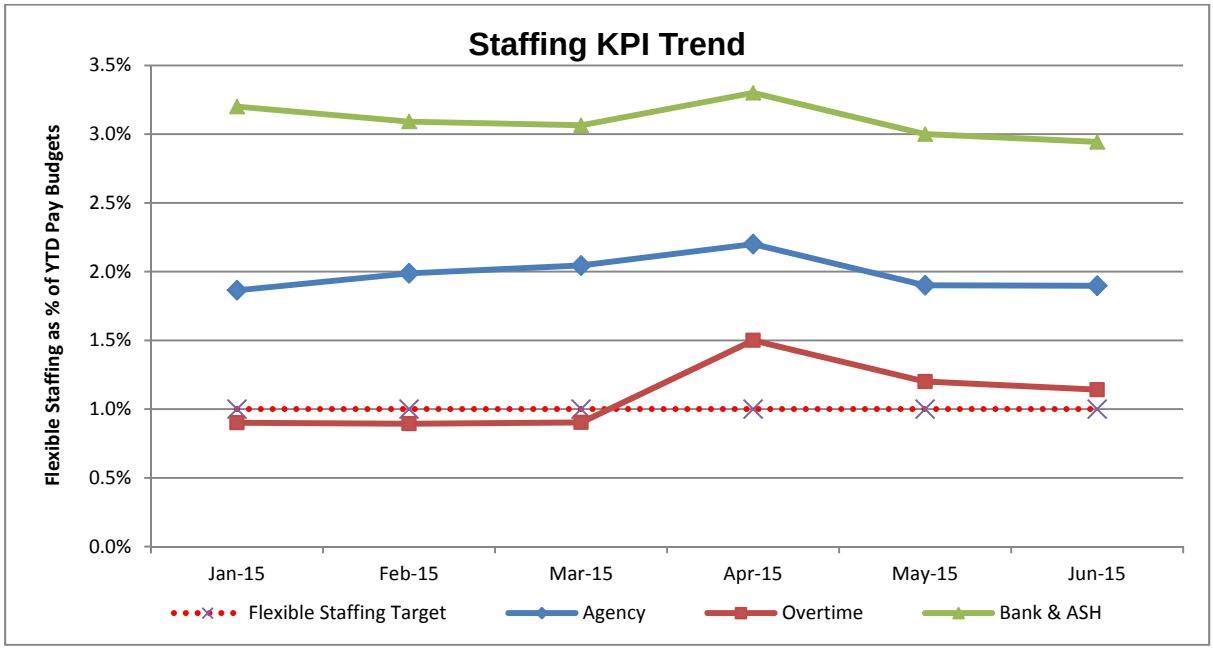
3.5 Financial Drivers

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

| Tolerance | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|
| Agency (1%) | 2.0% | 2.0% | 2.2% | 1.9% | 1.9% |
| Overtime (1%) | 0.9% | 0.9% | 1.5% | 1.2% | 1.1% |
| Bank & ASH (flexed against establishment) | 3.1% | 3.1% | 3.3% | 3.0% | 2.9% |
| Establishment (90%-95%) | 93.4% | 92.8% | 94.0% | 94.1% | 93.7% |
| **Total** | **99.3%** | **98.8%** | **101.0%** | **100.2%** | **99.7%** |

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for Agency and Overtime, and flexed in correlation to staff in post for Bank & ASH. For June 2015 the tolerance for Bank and ASH is 4.3% of pay budgets.

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




Additional staffing expenditure is 6.0% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (40%), enhanced observations (23%) and sickness (19%).

3.6 Continuity of Service Risk Rating and Indicators

3.6.1 The Continuity of Service Risk Rating was assessed as 3 at 30 June 2015 and is in line with plan.

3.6.2 Debt service cover assesses the level of operating surplus generated to ensure a Trust is able to cover all debt repayments due in the reporting period.

The Trust has a debt service cover of 1.37x (can cover debt payments due 1.37 times), which is in line with plan and is rated as a 2 in the CoSRR metrics.

3.6.3 The liquidity position is 34.6 days which marginally behind and is rated as a 4 in the CoSRR metrics.

3.6.4 The margins on CoSRR risk ratings are as follows:

- Debt service cover - to reduce to a 1 a surplus decrease of £522k is required.
- Liquidity - to reduce to a 3 a working capital reduction of £25,203k is required.

**Continuity of Services Risk Rating at 30 June 2015**

| Monitors Rating Guide | Weighting | Rating Categories | | | |
|---|---|---|---|---|---|
| | % | 4 | 3 | 2 | 1 |
| Debt Service Cover | 50 | 2.50 | 1.75 | 1.25 | < 1.25 |
| Liquidity | 50 | 0 | -7 | -14 | <-14 |

| TEWV Performance | Weighting | Rating Categories | | | |
|---|---|---|---|---|---|
| | % | 4 | 3 | 2 | 1 |
| Debt Service Cover | 50 | | | 1.37x | |
| Liquidity | 50 | 34.6 Days | | | |

**Overall Finance Continuity of Services Risk Rating** **3**

3.6.5 2.9% of total receivables (£63k) are over 90 days past their due date. This is with the 5% finance risk tolerance set by Monitor.

3.6.6 0.5% of total payables invoices (£45k) held for payment are over 90 days past their due date. This is within the 5% finance risk tolerance set by Monitor.

3.6.7 The cash balance at 30 June 2015 is £43,932k and represents 61.1 days of annualised operating expenses.

3.6.8 Actual capital expenditure is 89% and is within Monitor tolerances.

3.6.9 The Trust does not anticipate the quarterly Continuity of Services Risk Rating will be less than 3 in the next 12 months.

## 4. IMPLICATIONS / RISKS

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

## 5. CONCLUSIONS

5.1 The comprehensive income outturn for the period ending 30 June 2015 is a surplus of £1,834k, which is equivalent to 2.5% of turnover and is marginally ahead of plan.

5.2 The Trust is ahead of plan for identified Cash Releasing Efficiency Savings at 30 June 2015. The Trust continues to identify schemes to deliver CRES in 2016/17 whilst plans continue to be progressed for 2017/18.

5.3 The Continuity of Services Risk Rating for the Trust is 3 for the period ending 30 June 2015.

## 6 RECOMMENDATIONS

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

6.2 The Board of Directors are requested to approve the signing of the In Year Governance Statement confirming maintaining a continuity of service risk rating of at least 3 in the next 12 months.

**Colin Martin**
**Director of Finance**

**Item 14**

# BOARD OF DIRECTORS

**Date of Meeting:** 23rd July 2015
**Title:** Board Dashboard as at 30th June 2015
**Lead Director:** Sharon Pickering, Director of Planning, Performance & Communications
**Report for:** Assurance

## This report includes/supports the following areas:

| STRATEGIC GOALS: | ✓ |
|---|---|
| To provide excellent services working with the individual users of our services and their carers to promote recovery and well being | ✓ |
| 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 our communities | ✓ |
| To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities | ✓ |

| CQC REGISTRATION: Outcomes (✓) | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | ✓ | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | ✓ | Meeting nutritional needs | | Co-operating with other providers | ✓ |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | ✓ | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | ✓ | Staffing | ✓ | Supporting workers | ✓ |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | ✓ | Complaints | ✓ |
| Notification of death of a person who uses services | ✓ | Notification of death or AWOL of person detained under MHA | ✓ | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | ✓ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

**BOARD OF DIRECTORS**

**Date of Meeting:** **23rd July 2015**

**Title:** **Board Dashboard as at 30th June 2015**

## 1 INTRODUCTION & PURPOSE

1.1 To present to the Board the Trust Dashboard **(Appendix 1)** as at 30th June 2015 in order to identify any significant risks to the organisation in terms of operational delivery.

## 2. KEY RISKS/ISSUES

### 2.1 Key Issues/Risks

The key issues are as follows:

- The Quarter 1 Monitor Scorecard is attached in **Appendix 2** demonstrating that we have met all the Monitor Risk Assessment Framework targets for quarter 1.
- A data quality assessment for each indicator has been completed and is attached in **Appendix 3.** This shows that of those KPIs that have continued from 2014/15 six have an improved data quality assessment score compared to that completed in 2014/15. These are KPIs 8, 9,10,17,18 and 26. These improvements are due to either clearer definition/construction of the KPI or a move from a manual to an electronic collection process. 2 KPIs (11 and 17) still have a data quality assessment of less than 80%, however it is expected that these will improve over the remainder of the year linked to the delivery of the Datix Project.
- The report now contains the historical data for the Out of Locality admissions indicator.
- 17 of the 28 (61%) indicators are being reported as red in June 2015 compared to 16 in May 2015. Of those 17, 10 are showing an improving trend over the last 3 months compared to 7 in May 2015.

The key risks are as follows:

- Access - Both waiting time targets (KPIs 1 & 2) are showing an underperformance as at the end of June. KPI 1(external referrals) has deteriorated compared to the position in May and the 3 month trend is also one of deterioration. The Board received a briefing in April in terms of AMH waiting times and the action plan continues to be implemented. The key area of concern is in Children and Young People's Services across all three localities. There are action plans in each locality being implemented and in Durham and Darlington all new referrals are being offered an appointment within 4 weeks and work is ongoing to reduce the 'backlog' of those people still not seen who have already waited over 4 weeks. In Teesside it is expected that the 4 week waiting time will be achieved by September 2015. In terms of KPI 2 the previous 3 monthly trend

of improvement has continued in June although the performance in June was worse than in May.

- Psychological Therapies KPI 6 Access - Performance against this indicator has achieved the target for the first time since May 2013 which is due to a particular strong performance by the North Yorkshire service. In terms of KPI 7 Recovery Rate the Trust has failed to achieve the 50% recovery target and the 3 monthly trend is one of deterioration. North Yorkshire locality is also the only locality that has achieved the recovery rate target. In Durham the service has been operating with reduced staffing levels due to sickness, maternity leave and vacancies however a decision has been taken to try to over recruit to the vacancies given the level of turnover within the service. In Teesside an analysis of the records of those patients that have not achieve recovery has not highlighted any particular trends/themes.

- Out of Locality Admissions (KPI 12) – we achieved the target for a second month in June. Once again Teesside performed significantly better than target at 4.6% with Durham and Darlington slightly over target (15.53%). North Yorkshire continues to be an outlier compared to the other two localities.

- %age of patients readmitted to assessment and treatment beds within 30 days (KPI 13) – This indicator has continued to underperform compared to the target however the 3 monthly trend is one of improvement. Durham and Darlington and North Yorkshire accounted for 16 of the 18 readmissions within 30 days. It should be noted that the related indicators KPI 14 (number of times a patient has had 3 or more admissions in the past year) and KPI 15 (median number of days between admissions) are also both over target but are showing an improved position over the previous 3 months.

- Number of unexpected deaths classed as a serious incident (KPI 17) – this indicator has continued to underperform against the target and remains at a higher level in June 2015 compared to June 2014 and 2013. No particular trends have been identified.

- Inpatient satisfaction (KPI 18) – There has been a significant reduction in the %age of wards that have scored greater than 80% satisfaction in the patient survey. The localities that are underperforming are North Yorkshire and Forensic. Within Forensic 12 wards did not achieve 80% satisfaction (14.3%) however it should be noted that the response rates are low across the service.

- Appraisal (KPI 23) – There has been a slight improvement in June although the 3 monthly trend shows a deterioration. The event to look at how the IIC can support the proactive management of this indicator, for example by alerting staff and managers when non-compliance will be triggered, is to be held in July and it is expected that this will have a positive impact upon compliance rates.

2.3 **Appendix 4** provides further details of unexpected deaths. The breakdown by locality is now included.

## 3 RECOMMENDATIONS

It is recommended that the Board:

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

**Sharon Pickering**
**Director of Planning, Performance & Communications**

# Trust Dashboard Summary for TRUST

## Strategic Goal 1: To provide excellent services, working with the individual users of our services and their carers to promote recovery and well being

| | June 2015 | | | | April 2015 To June 2015 | | | Annual |
|---|---|---|---|---|---|---|---|---|
| | Target | Month | Status | Trend Arrow (3 Months) | Target | YTD | Status | Target |
| 1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral. | 98.00% | 80.42% |  |  | 98.00% | 80.99% |  | 98.00% |
| 2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral | 98.00% | 86.72% |  |  | 98.00% | 88.10% |  | 98.00% |
| 3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral. | 50.00% | 77.36% |  |  | 50.00% | 70.35% |  | 50.00% |
| 4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral. | 75.00% | 79.98% |  |  | 75.00% | 78.82% |  | 75.00% |
| 5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral. | 95.00% | 94.74% |  |  | 95.00% | 94.05% |  | 95.00% |
| 6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced) | 15.00% | 15.45% |  |  | 15.00% | 13.86% |  | 15.00% |
| 7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery | 50.00% | 46.47% |  |  | 50.00% | 46.88% |  | 50.00% |
| 8) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post-validated | 95.00% | 98.61% |  |  | 95.00% | 98.13% |  | 95.00% |
| 9) Percentage CPA 7 day follow up (AMH) - post-validated | 95.00% | 96.13% |  |  | 95.00% | 98.07% |  | 95.00% |
| 10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH) | 98.00% | 98.35% |  |  | 98.00% | 98.35% |  | 98.00% |
| 11) Percentage of community patients who state they have been involved in the development of their care plan (month behind) | 85.00% | 87.42% |  |  | 85.00% | 89.39% |  | 85.00% |

# Trust Dashboard Summary for TRUST

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

| | June 2015 | | | | April 2015 To June 2015 | | | Annual |
|---|---|---|---|---|---|---|---|---|
| | Target | Month | Status | Trend Arrow (3 Months) | Target | YTD | Status | Target |
| 12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated | 15.00% | 14.96% |  |  | 15.00% | 17.17% |  | 15.00% |
| 13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) | 15.00% | 28.12% |  |  | 15.00% | 27.27% |  | 15.00% |
| 14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) | 17.00 | 20.00 |  |  | 52.00 | 69.00 |  | 209.00 |
| 15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP) | 146.00 | 108.00 |  |  | 146.00 | 98.00 |  | 146.00 |
| 16) Percentage of appointments cancelled by the Trust | 0.67% | 1.08% |  |  | 0.67% | 1.10% |  | 0.67% |
| 17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated | 1.00 | 1.64 |  |  | 3.00 | 4.73 |  | 12.00 |
| 18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind) | 75.00% | 55.32% |  |  | 75.00% | 66.39% |  | 75.00% |
| 19) Mean level of improvement on SWEMWBS (AMH only) | 6.27 | 6.12 |  |  | 6.27 | 5.62 |  | 6.27 |
| 20) Mean level of improvement on SWEMWBS (MHSOP only) | 3.67 | 2.12 |  |  | 3.67 | 2.67 |  | 3.67 |
| 21) Percentage of HoNOS ratings that have improved in the non-psychotic and psychosis super classes for patients that are in scope (AMH and MHSOP) - snapshot | 50.00% | 48.89% |  |  | 50.00% | 48.89% |  | 50.00% |
| 22) Percentage of HoNOS ratings that have improved in the organic super classes for patients that are in scope (AMH and MHSOP) - snapshot | 33.00% | 30.93% |  |  | 33.00% | 30.93% |  | 33.00% |

# Trust Dashboard Summary for TRUST

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

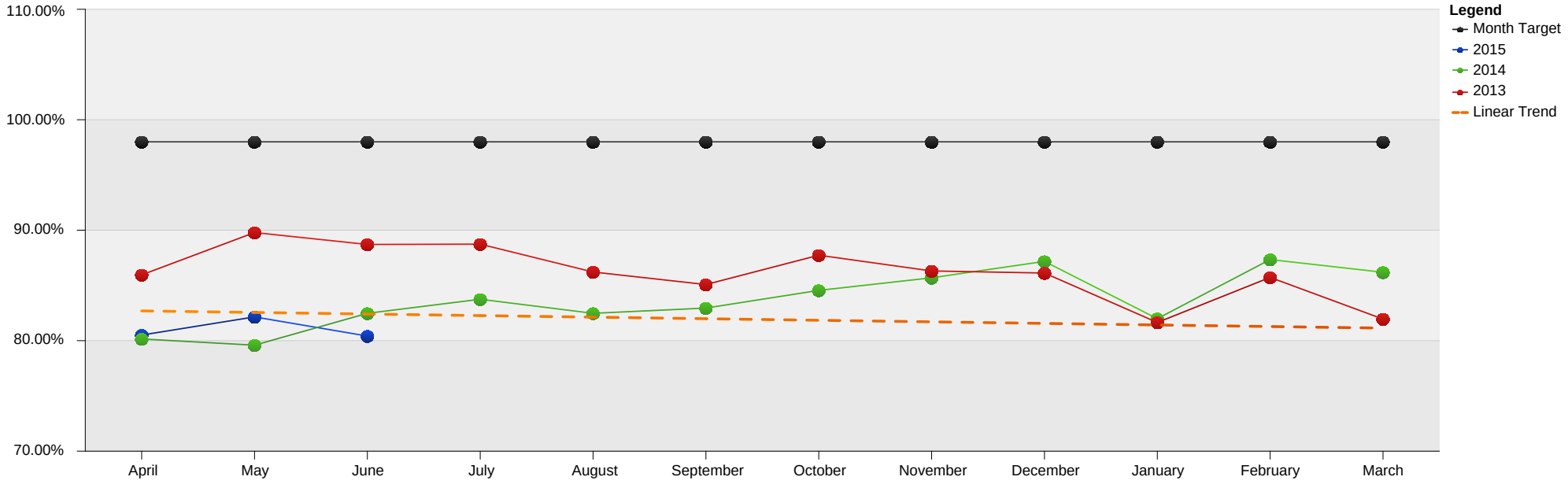
| | June 2015 | | | | April 2015 To June 2015 | | | Annual |
|---|---|---|---|---|---|---|---|---|
| | Target | Month | Status | Trend Arrow (3 Months) | Target | YTD | Status | Target |
| 23) Percentage of staff in post more than 12 months with a current appraisal (snapshot) | 95.00% | 87.57% |  |  | 95.00% | 87.57% |  | 95.00% |
| 24) Percentage compliance with mandatory and statutory training (snapshot) | 95.00% | 87.94% |  |  | 95.00% | 87.94% |  | 95.00% |
| 25) Percentage Sickness Absence Rate (month behind) | 4.50% | 4.55% |  |  | 4.50% | 4.67% |  | 4.50% |

## Strategic Goal 5: To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve

| | June 2015 | | | | April 2015 To June 2015 | | | Annual |
|---|---|---|---|---|---|---|---|---|
| | Target | Month | Status | Trend Arrow (3 Months) | Target | YTD | Status | Target |
| 26) Number of reds on CQC action plans (including MHA action plans) | 0.00 | 0.00 |  |  | 0.00 | 0.00 |  | 0.00 |
| 27) Total number of External Referrals into the Trust Services | 5,748.00 | 6,412.00 |  |  | 17,435.00 | 18,123.00 |  | 69,931.00 |
| 28) Delivery of our financial plan (I and E) | 6,300.00 | -4,000.00 |  |  | -1,781,000.00 | -1,834,000.00 |  | -4,784,000.00 |

# Trust Dashboard Graphs for TRUST

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



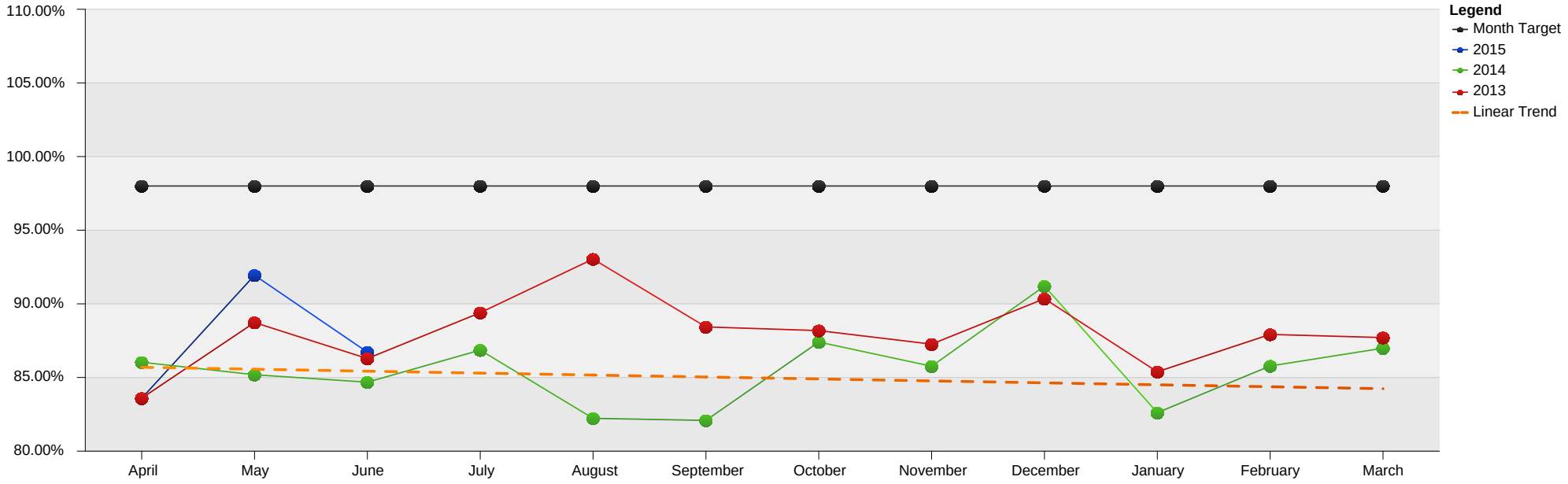

| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral. | 80.42% | 80.99% | 78.26% | 78.96% | 85.08% | 86.66% | 73.85% | 73.51% | 100.00% | 99.77% |

**Narrative**

The Trust position for June 2015 is 80.42%, which relates to 763 patients out of 3896 who had waited longer than 4 weeks for a first appointment. This is 17.58% below target, a deterioration on May 2015 performance and a deteriorating 3 monthly position. The Trust position for the financial year to date is 80.99%, which is 17.01% below target.The specific areas of concern are:• Durham and Darlington CYP at 33.33% (160 patients) and Adult Mental Health at 85.91% (105 patients). The position in CYP is primarily attributable to large numbers of referrals for the Primary Mental Health Worker teams. A 15 point action plan is in place; 9 of which have been completed. Processes are in place to implement the remaining 6.• Teesside CYP at 53.87% (161 patients). A plan is in place to allocate new referrals with an appointment within 4 weeks. This is on track to be achieved by September 2015.• North Yorkshire CYP at 53.21% (51 patients), Mental Health Services for Older People at 73.02% (85 patients) and Adult Mental Health at 80.28% (100 patients). An action plan commenced within MHSOP at the beginning of July, which is scheduled to run for ten weeks to September. The issue within AMH is primarily attributable to RIPON CMHT which experiencing staffing pressures and Primary Care in Hambleton & Richmondshire.Based on past performance and June's performance there is a significant risk that we will not achieve the annual target of 98%. The annual outturn for 2014/15 was 83.73%.

# Trust Dashboard Graphs for TRUST

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

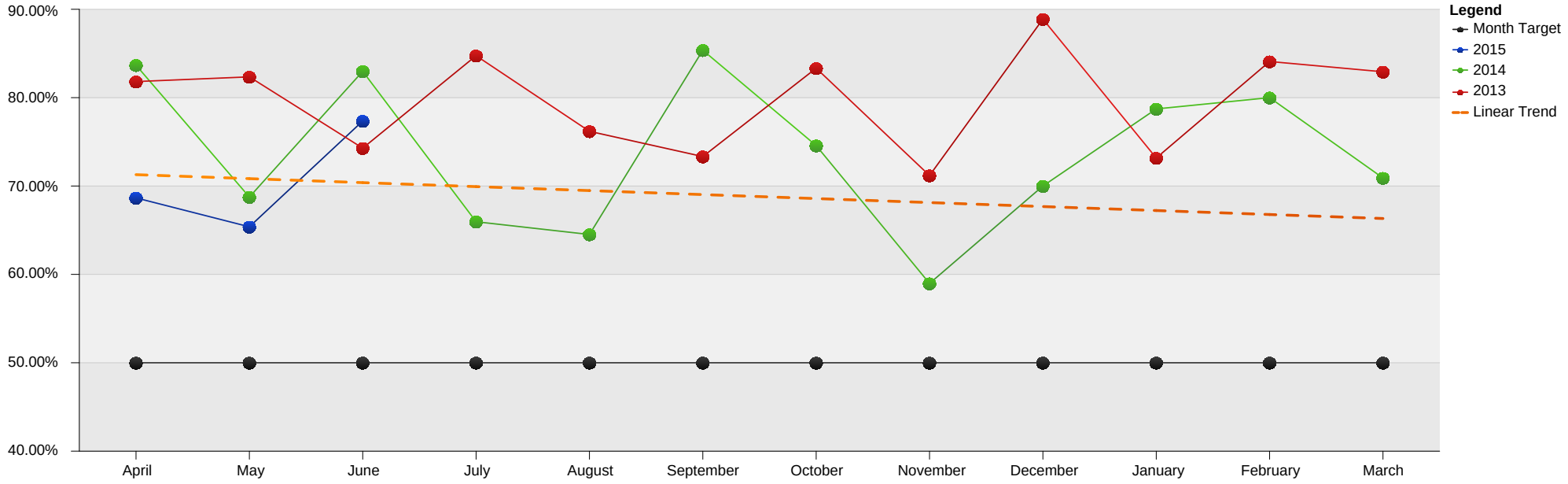



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral | 86.72% | 88.10% | 81.66% | 86.89% | 90.44% | 90.53% | 90.82% | 88.99% | 62.50% | 51.35% |

| Narrative |
|---|
| The Trust position for June 2015 is 86.72%, which relates to 317 patients out of 2387 that were not seen within 4 weeks of an internal referral. This is 11.28% below target and a considerable deterioration on May 2015 performance; however the trend over the past 3 months is one of improvement. The Trust position for the financial year to date is 88.10%, which is 9.90% below target.The specific areas of concern are:• Durham and Darlington Children & Young People's Services at 63.16% (77 patients), Adult Mental Health Services at 82.96% (77 patients)• Teesside Children & Young People's Services at 64.12% (61 patients)• Forensic Services at 62.50% (12 patients), of which 8 are within Forensic Learning Disability autism services.Based on past performance and June's performance there is a significant risk that we will not achieve the annual target of 98%. The annual outturn for 2014/15 was 85.79%. |

# Trust Dashboard Graphs for TRUST

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

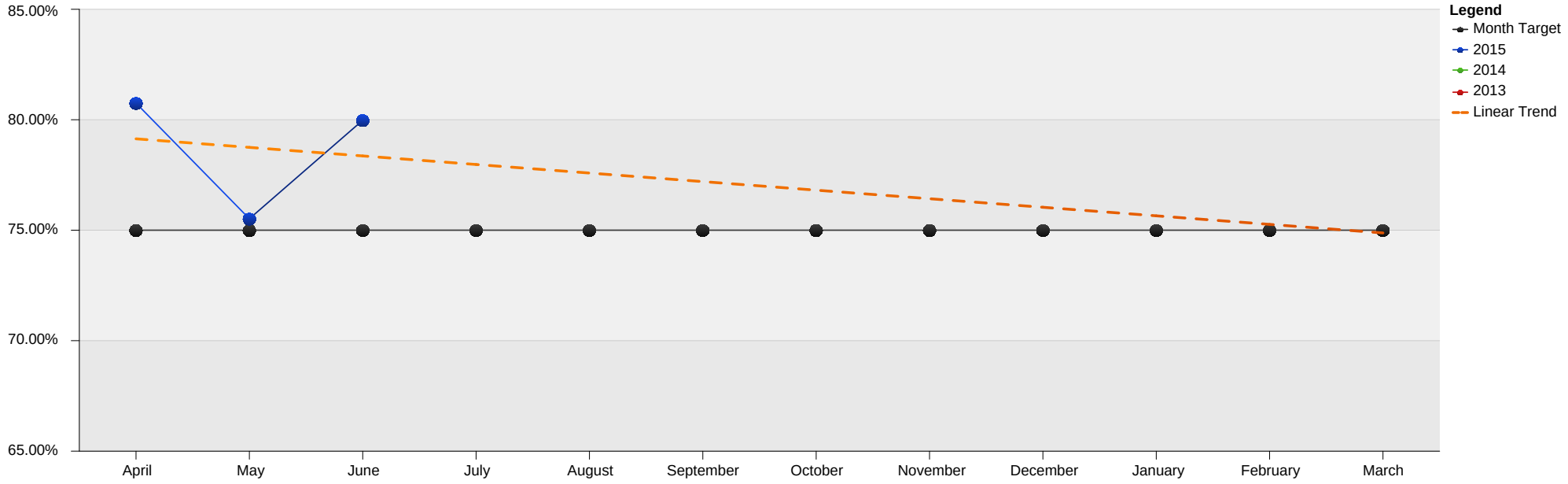



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral. | 77.36% | 70.35% | 71.43% | 58.90% | 84.62% | 78.87% | 66.67% | 78.57% | NA | NA |

| Narrative |
|---|
| The Trust position for June 2015 is 77.36%, which relates to 12 patients out of 53 that were not treated with a NICE approved care package within 2 weeks of referral. This is 27.36% above target and an improvement on May 2015 performance. All localities are achieving target. The Trust position for the financial year to date is 70.35%, which is 20.35% above target.Based on past performance and June's performance it is anticipated that we will achieve the annual target of 50%. The annual outturn for 2014/15 was 74.22%. |

# Trust Dashboard Graphs for TRUST

## 4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.



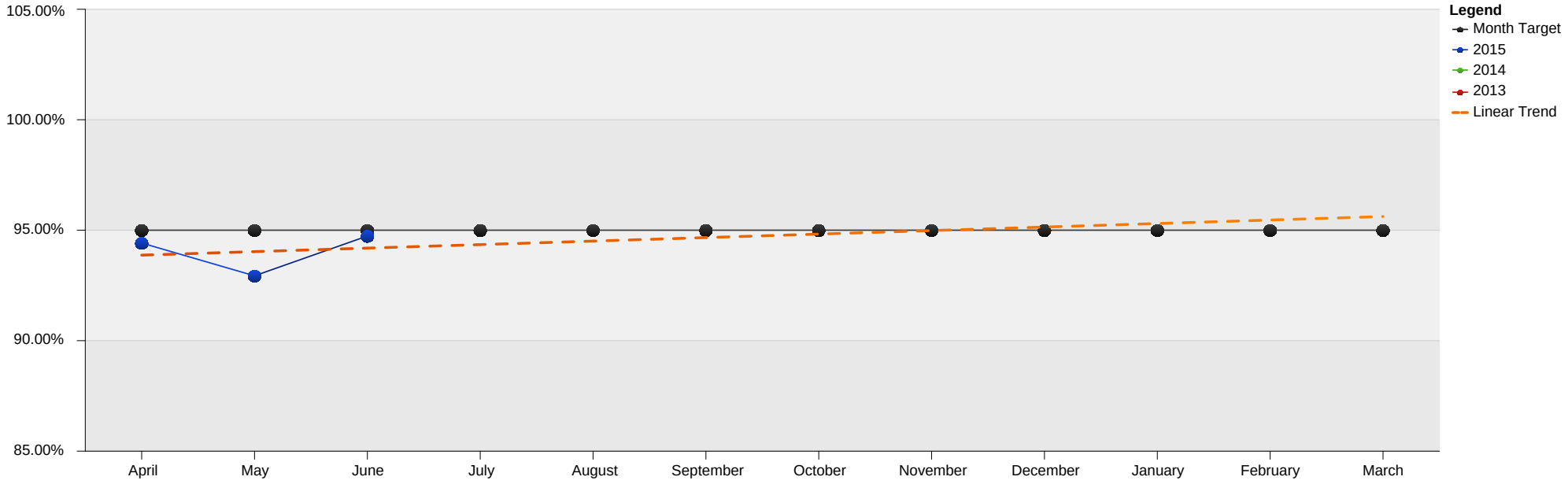

| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral. | 79.98% | 78.82% | 98.65% | 99.08% | 64.15% | 61.28% | 58.36% | 61.36% | NA | NA |

**Narrative**

The Trust position for June 2015 is 79.98%, which relates to 175 patients out of 874 that were not treated within 6 weeks of referral. This is 4.98% above target and an improvement on May 2015 performance. Only Durham & Darlington are achieving target. The Trust position for the financial year to date is 78.82%, which is 3.82% above target.Hartlepool and Stockton CCG (67.31%) and South Tees CCG (62.62%) report below target but have reported an improvement on May. The service has an action plan in place to address the areas of underperformance and the service has increased the number of sessions available to ensure that patients commence treatment as soon as possible after referral. For North Yorkshire, the 6 weeks position is 58.36%. An action plan is in place to ensure patients are treated within 6 weeks of referral, which has highlighted a number of data recording issues; work is underway to rectify this issue.Based on past performance and June's performance it is anticipated that we will achieve the annual target of 75%.Data only started to be collected from April 2015; therefore no comparative data for 2014/15 is available.

# Trust Dashboard Graphs for TRUST

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

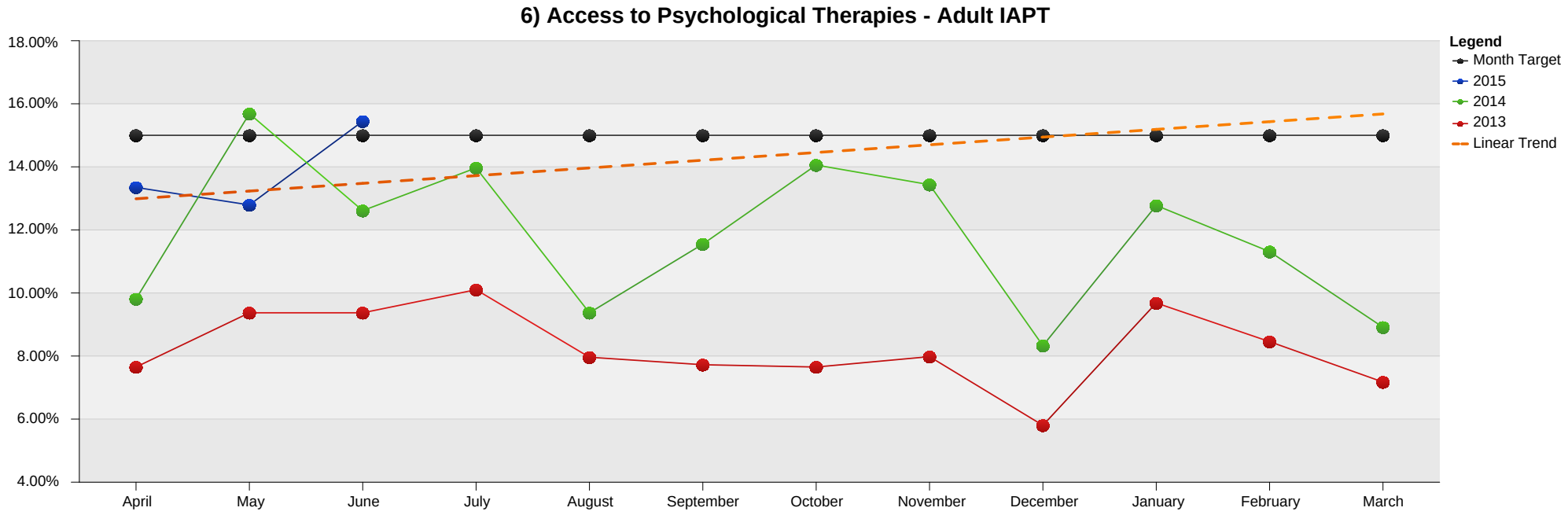



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral. | 94.74% | 94.05% | 99.78% | 99.83% | 81.76% | 78.26% | 94.05% | 94.88% | NA | NA |

**Narrative**

The Trust position for June 2015 is 94.74%, which relates to 46 patients out of 874 that were not treated within 18 weeks of referral. This is 0.26% below target but an improvement on May 2015 performance. Only Durham & Darlington are achieving target. The Trust position for the financial year to date is 94.05%, which is 0.95% below target.Teesside reports 81.76% (29 patients not treated within 18 weeks). Hartlepool and Stockton CCG (86.54%) and South Tees CCG (79.44%) report below target. North Yorkshire reports 94.05% (16 patients) - this is part of the ongoing service improvement action plan.Based on past performance and June's performance there is a risk that we will not achieve the annual target of 98%. Data only started to be collected from April 2015; therefore no comparative data for 2014/15 is available.

# Trust Dashboard Graphs for TRUST




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced) | 15.45% | 13.86% | 14.35% | 12.92% | NA | NA | 17.14% | 15.31% | NA | NA |

**Narrative**

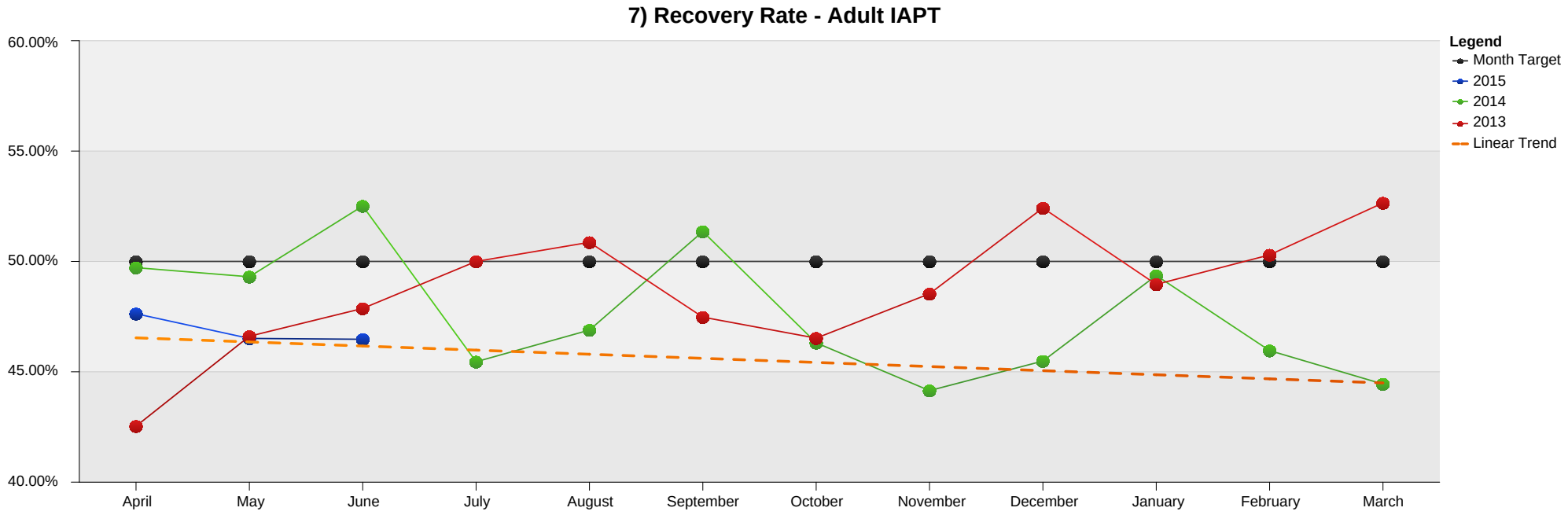
The Trust position for June 2015 is 15.45% which equates to 1391 people entering treatment from 9005 of the general population. This is 0.45% above the target of 15% and is an improvement on May performance, reporting above target for the first time since May 2014. The Trust position for the financial year to date is 13.86%, which is 1.14% below target.

North Durham CCG (11.81%), DDES CCG (15.04%) and Darlington (18.80%) all report an improvement on last month. During June interviews took place and 26 therapy support workers have been appointed. Once in post they will help with screening and telephone treatments to facilitate patients entering treatment quickly.

North Yorkshire has significantly improved service wide; Hambleton, Richmondshire & Whitby CCG (21.18%) and Scarborough & Ryedale CCG (18.25%) are achieving target, whilst Harrogate & Rural CCG (14.06%) and Vale of York CCG (5.35%) are below. An action plan is in place to address this and recruitment processes within the service continue.
Based on past performance there is a risk that we will not achieve the annual target of 15%; however, should the improvement reported during June continue the target can be achieved.

The annual outturn for 2014/15 was 11.82%.

# Trust Dashboard Graphs for TRUST




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery | 46.47% | 46.88% | 42.34% | 43.85% | 47.33% | 49.23% | 53.22% | 49.74% | NA | NA |

**Narrative**

The Trust position for June 2015 is 46.47%, with 425 people out of 794 not achieving recovery. This is 3.53% below the target of 50% and a very slight deterioration on May performance and a deteriorating 3 monthly trend. Only North Yorkshire is reporting above target. The Trust position for the financial year to date is 46.88%, which is 3.12% below target.

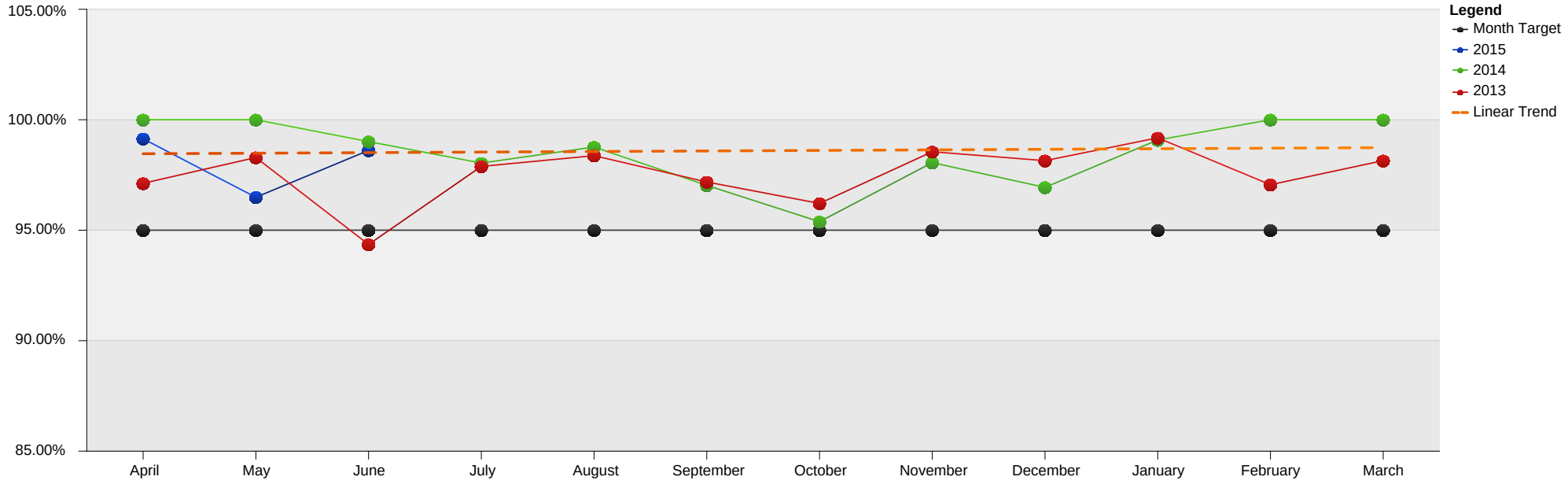
All 3 CCGs in Durham & Darlington have seen a decline in performance; North Durham CCG (45.41%) and DDES CCG (40.74%) and Darlington CCG (35.85%). Caseload management work is underway to ensure effective discharge management; however all teams have been impacted by maternity leave and staff sickness and there are staff vacancies in North Durham and DDES.
Both Hartlepool and Stockton CCG (42.86%) and South Tees CCG (49.50%) have reported a deterioration in performance. The action plan is progressing and an initial analysis of records for those patients that have not completed treatment has not highlighted anything of note. The service has changed its approach to the analysis and this has been completed for the first month; however this will need to be repeated further before any patterns or trends can be identified.

Based on past performance and June's performance, there is a risk that we will not achieve the annual target of 50%, unless further action is taken.

The annual outturn for 2014/15 was 47.63%.

# Trust Dashboard Graphs for TRUST

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

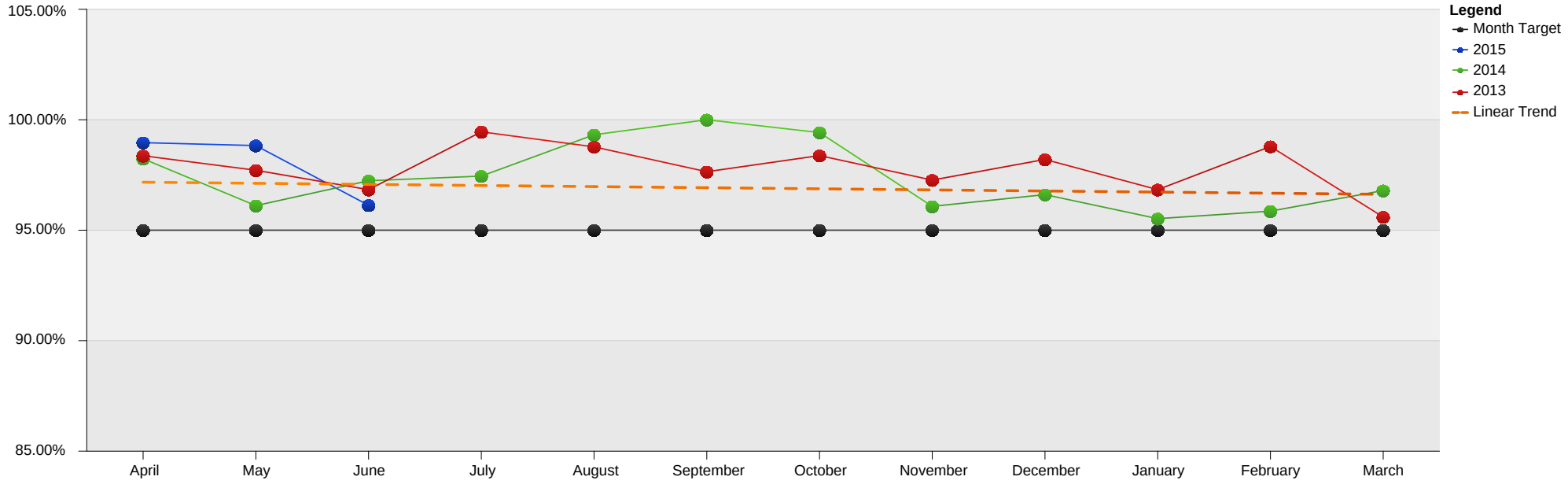



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 8) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post-validated | 98.61% | 98.13% | 100.00% | 97.32% | 98.41% | 98.27% | 97.22% | 98.88% | NA | NA |

| Narrative |
|---|
| The Trust post validated position for June 2015 is 98.61%, which relates to 2 patients out of 144 that were not seen by a Crisis Home Treatment Team prior to admission. This is 3.61% above the target and an improvement on May performance. The Trust post validated position for the financial year to date is 98.13%, which is 3.13% above target.<br><br>Based on past performance and June's performance, it is anticipated that we will achieve the annual target of 95%.<br><br>The annual outturn for 2014/15 was 98.42%. |

# Trust Dashboard Graphs for TRUST

## 9) Percentage CPA 7 day follow up (AMH) - post-validated

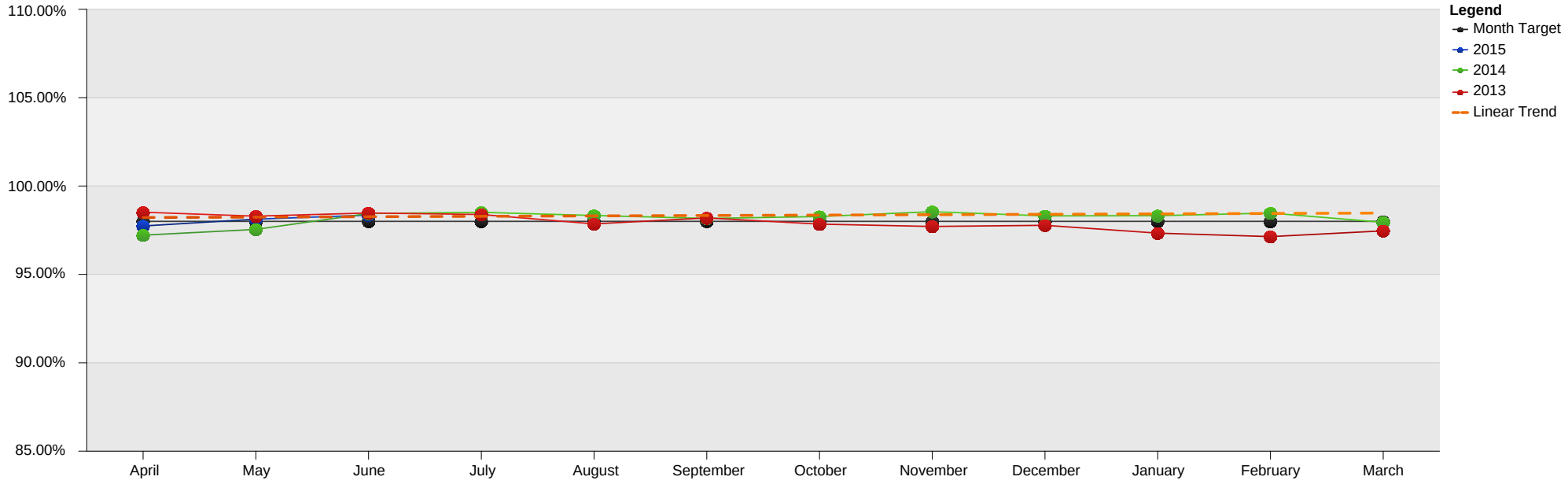



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 9) Percentage CPA 7 day follow up (AMH) - post-validated | 96.13% | 98.07% | 97.10% | 98.09% | 96.15% | 98.54% | 94.12% | 97.14% | NA | NA |

| Narrative |
|---|
| The Trust post validated position for June 2015 is 96.13% which relates to 6 patients out of 155 that were not followed up within 7 days of discharge. This is 1.13% above the target but a deterioration on May performance. The Trust post validated position for the financial year to date is 98.07%, which is 3.07% above target.Based on past performance and June's performance, it is anticipated that we will achieve the annual target of 95%.The annual outturn for 2014/15 was 97.42%. |

# Trust Dashboard Graphs for TRUST

## 10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)

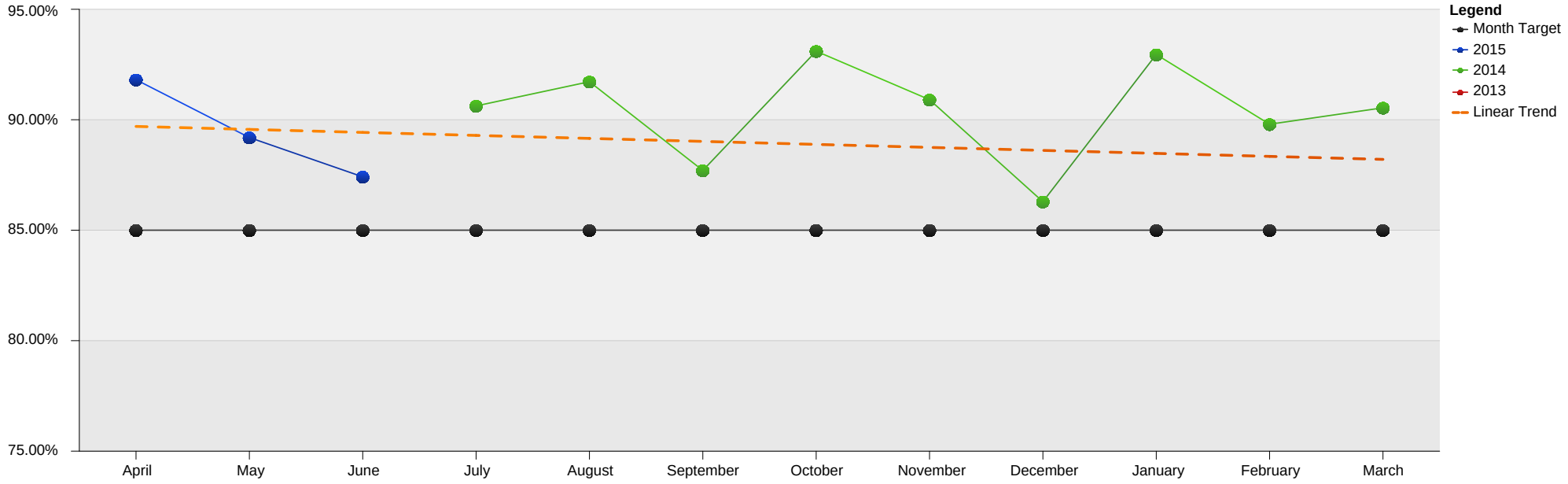



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH) | 98.35% | 98.35% | 97.94% | 97.94% | 99.55% | 99.55% | 97.53% | 97.53% | | |

| Narrative |
|---|
| The Trust position for June 2015 is 98.35% which relates to 70 patients out of 4248 that had not had a formal review documented within 12 months. This is 3.35% above the Monitor target of 95%, 0.35% above the Trust target of 98% and a very slight improvement on May performance. June is the first month in 2015/16 where the Trust target has been achieved.Both Durham & Darlington and North Yorkshire are failing to achieve target and work continues to address this. Focused work is being implemented within Durham and a daily report out is taking place to ensure this indicator is monitored by team and locality managers. The position within North Yorkshire is primarily attributable to Scarborough and investigations are currently underway to ascertain any underlying reasons.Whilst we did not achieved the Trust target in April and May it is expected that we will achieve the annual target of 98%.The annual outturn for 2014/15 was 97.90%. |

# Trust Dashboard Graphs for TRUST

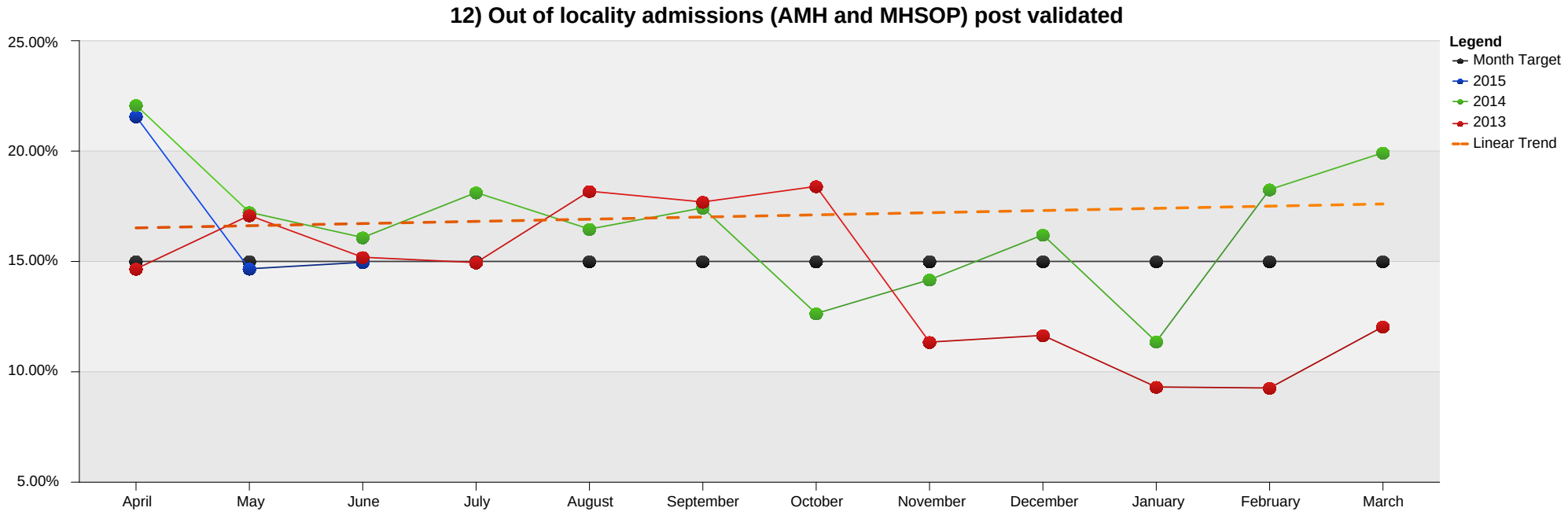
## 11) Community patients involved in the development of their care plan (month behind)




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 11) Percentage of community patients who state they have been involved in the development of their care plan (month behind) | 87.42% | 89.39% | 88.54% | 90.03% | 88.49% | 88.76% | 84.06% | 90.60% | 100.00% | 90.00% |

| Narrative |
|---|
| The position reported in June relates to May performance. The Trust position for May 2015 is 87.42%, which relates to 56 patients out of 445 that state they have not been involved in the development of their care plan. This is 2.42% above the target of 85% but a deterioration on the position reported for April, reflecting a decreasing trend over the last three months. The Trust position for the financial year to date is 89.39%, which is 4.39% above target.<br><br>Based on past performance and May's performance, it is anticipated that we will achieve the annual target of 85%.<br><br>As this indicator is reported a month behind, it must be noted the financial year will be calculated from March of the previous year to February within the current year (inclusive).<br><br>The annual outturn for 2014/15 was 90.58% |

# Trust Dashboard Graphs for TRUST

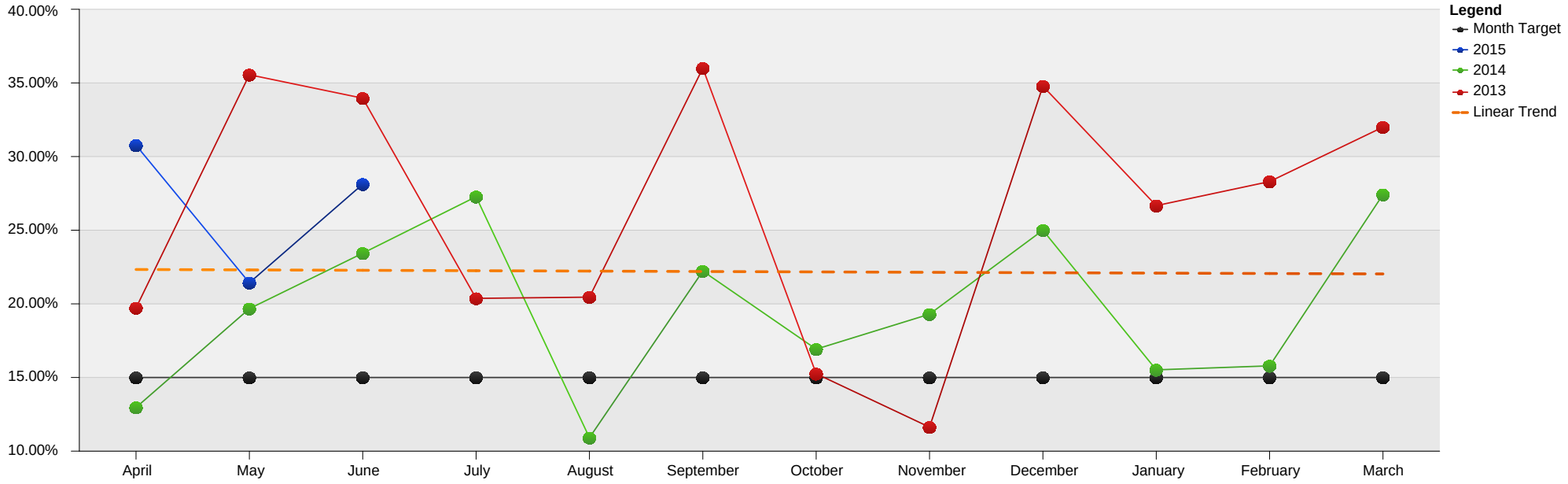



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated | 14.96% | 17.17% | 15.53% | 17.47% | 4.60% | 6.23% | 28.12% | 31.89% | NA | NA |

| Narrative |
|---|
| The Trust position for June 2015 is 14.96%, which relates to 38 admissions out of 254 that were admitted to out of locality assessment and treatment wards. This is 0.04% below the target of 15% and a slight deterioration on the position reported in May. Only Teesside Locality is reporting above target. The Trust position for the financial year to date is 17.17%, which is 2.17% above target.Of the 38 patients admitted to an 'out of locality' bed:• 32 (84.21%) were due to no beds being available at their local hospital – AMH 22, MHSOP 10• 6 (15.79%) breaches were due to other reasons.The localities continue to investigate ways in which they can improve OOL admissionsThe Trust has reported an improving trend over the last three months and has reported lower positions for April to June 2015 compared to the same positions during 2014. Should this improvement be sustained we will achieve the annual target of 15.00%. |

# Trust Dashboard Graphs for TRUST

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



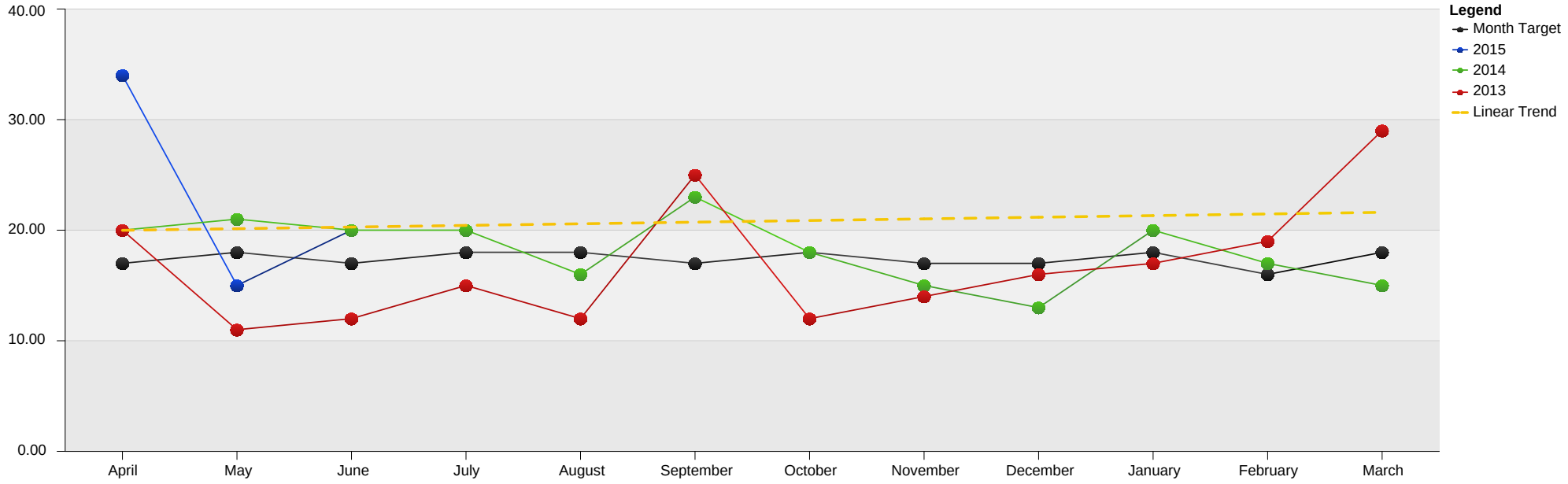

| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) | 28.12% | 27.27% | 34.62% | 28.57% | 12.50% | 21.21% | 33.33% | 32.35% | NA | NA |

**Narrative**

The Trust position for June 2015 is 28.12%, which relates to 18 patients out of 64 that were readmitted within 30 days. This is 13.12% above the target of 15% and a significant deterioration on the position reported in May. Performance reported for the first three months of this financial year has consistently been higher than the equivalent months in 2014/15. The Trust position for the financial year to date is 27.27%, which is 12.27% above target.Of the 18 readmissions:• 9 (50.00%) were within Durham & Darlington – AMH 9, MHSOP 0• 2 (11.11%) were within Teesside - AMH 1, MHSOP 1• 7 (38.89%) were within North Yorkshire - AMH 7, MHSOP 0Investigations have indicated that some admissions may be recorded incorrectly. This is being addressed within the services.Based on past performance and June's performance, there is a risk that we will not achieve the annual target of 15%, unless further action is taken.The annual outturn for 2014/15 was 19.89%.

# Trust Dashboard Graphs for TRUST

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




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) | 20.00 | 69.00 | 9.00 | 25.00 | 4.00 | 19.00 | 6.00 | 24.00 | NA | NA |

**Narrative**

The Trust position for June 2015 is 20, which is 3 above the target of 17 and a deterioration on the position reported in May, although the 3 monthly trend is one of improvement. The Trust position for the financial year to date is 69, which is 17 above target.

Of the 20 readmissions:

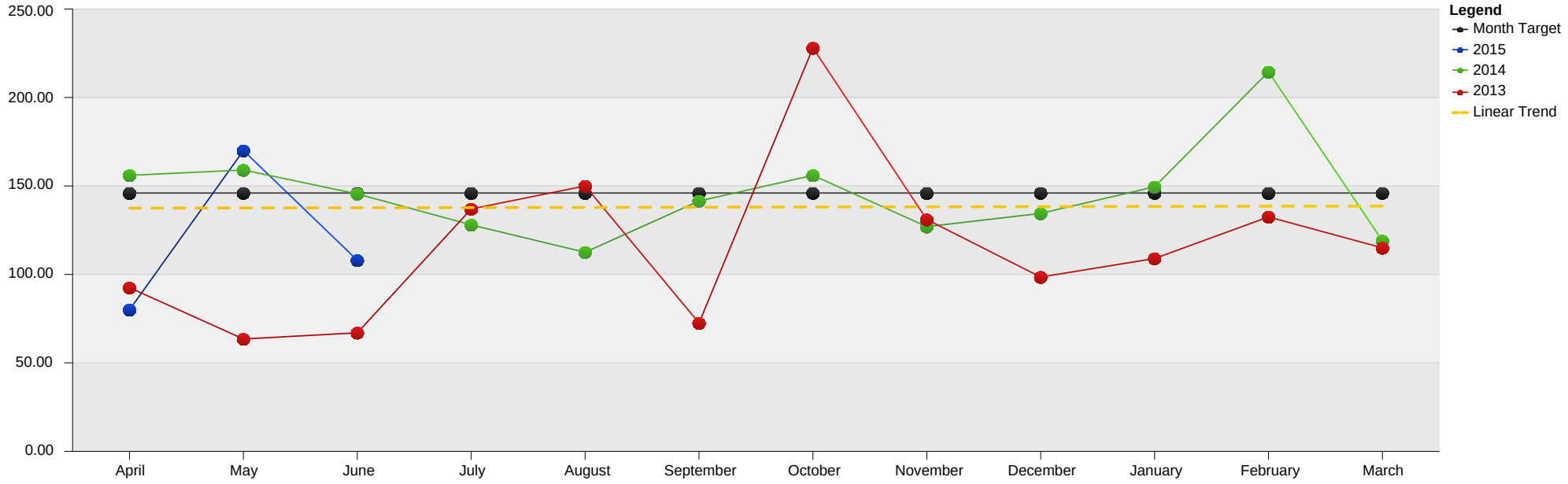
- 9 (45.00%) were within Durham & Darlington – AMH 9, MHSOP 0
- 4 (20.00%) were within Teesside - AMH 3, MHSOP 1
- 6 (30.00%) were within North Yorkshire - AMH 6, MHSOP 0
- 1 readmission is attributable to an out of area patient that has been incorrectly included within the indicator

Based on past performance and June's performance, there is a risk that we will not achieve the annual target of 209, unless further action is taken.

The annual outturn for 2014/15 was 219.

# Trust Dashboard Graphs for TRUST

## 15) Median number of days between admissions (AMH & MHSOP)

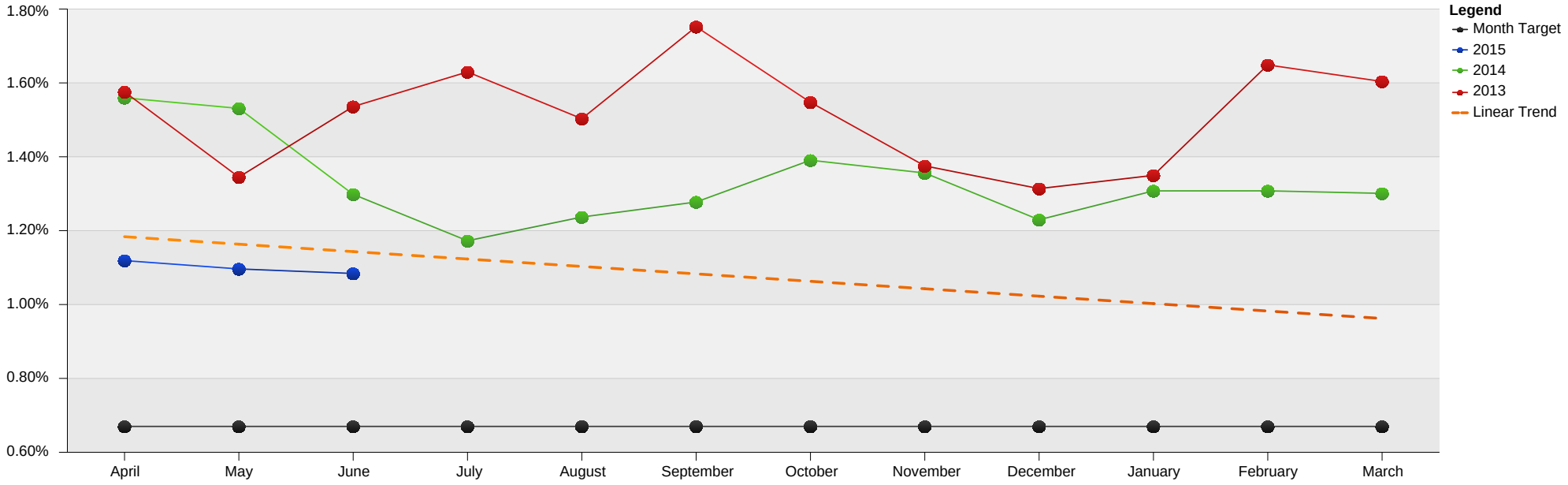



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP) | 108.00 | 98.00 | 94.00 | 108.50 | 485.00 | 133.00 | 52.00 | 79.00 | NA | NA |

| Narrative |
|---|
| The Trust position for June 2015 is 108, which is 38 below the target of 146 and a significant deterioration on May performance. The Trust position for the financial year to date is 98, which is 48 below target. |
| Based on past performance and June's performance, there is a risk that we will not achieve the annual target of 146, unless further action is taken. |
| The annual outturn for 2014/15 was 139. |

# Trust Dashboard Graphs for TRUST

## 16) Percentage of appointments cancelled by the Trust




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 16) Percentage of appointments cancelled by the Trust | 1.08% | 1.10% | 1.14% | 1.09% | 0.97% | 1.11% | 1.38% | 1.29% | 0.00% | 0.09% |

**Narrative**

The Trust position for June 2015 is 1.08%, which relates to 902 appointments out of 83,201 that have been cancelled. This is 0.41% above the target of 0.67% but a slight improvement compared to May performance. The Trust position for the financial year to date is 1.10%, which is 0.43% above target.

Only Forensics are achieving target with no appointments cancelled by the Trust.

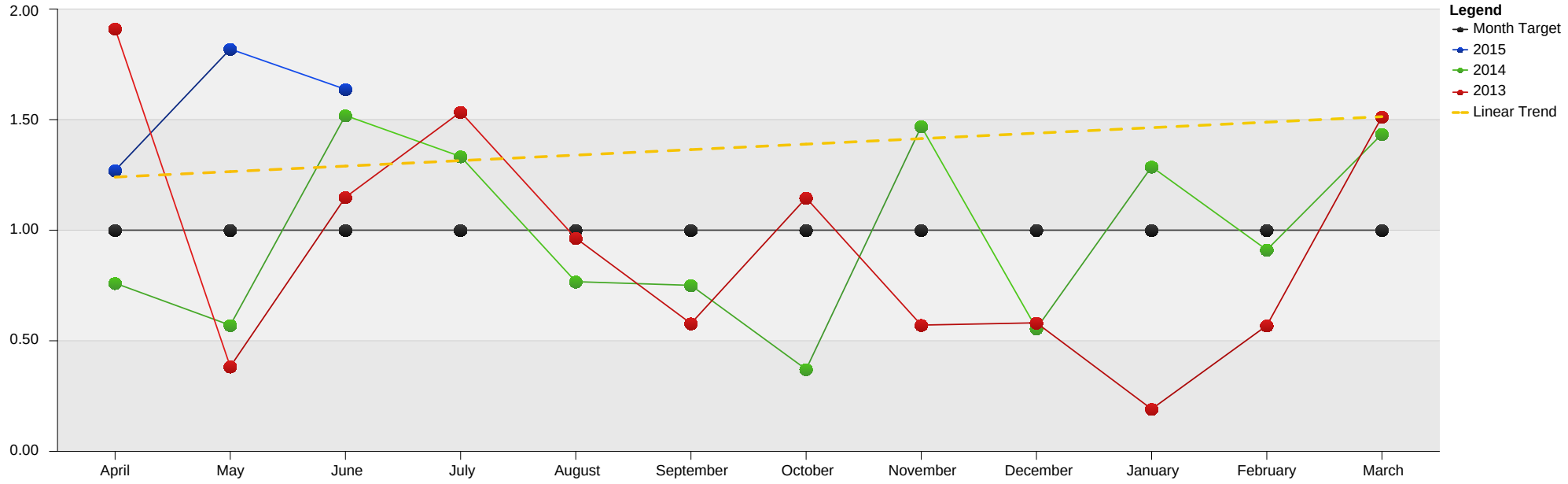
All localities are failing to achieve target; however, it has been identified that some of these cancellations may be due to how clinics are managed and investigations into this continue. This work is being coordinated by the Data Quality Working Group who report progress to the Data Quality Group on a regular basis.

Whilst June has reported the lowest percentage of cancellations over the last two years, there remains a risk that we will not achieve the annual target of 0.67%, unless further action is taken.

The annual outturn for 2014/15 was 1.33%.

# Trust Dashboard Graphs for TRUST

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



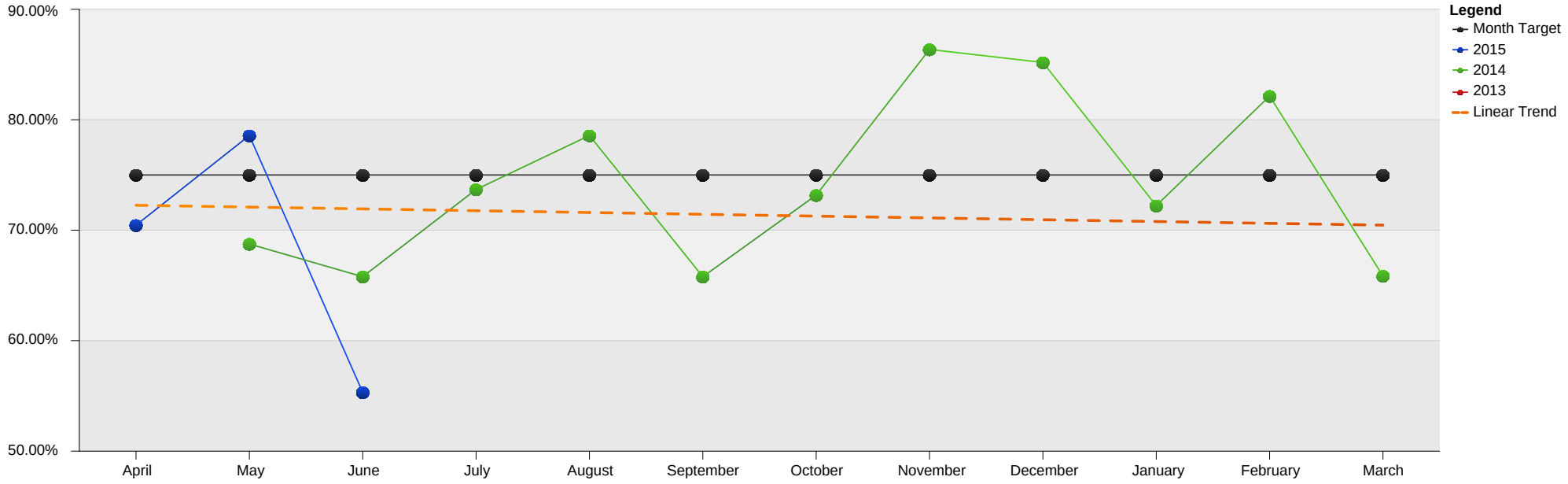

| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated | 1.64 | 4.73 | 1.58 | 3.94 | 2.43 | 4.88 | 0.82 | 6.49 | 0.00 | 0.00 |

**Narrative**

The Trust position for June 2015 is 1.64, which is 0.64 above the target of 1.00 but an improvement on May performance. This rate relates to 9 unexpected deaths reported in May; 4 in Durham and Darlington, 1 in North Yorkshire and 4 in Teesside. No patterns or trends have been identified. The Trust position for the financial year to date is 4.73, which is 1.73 above target.Performance reported for the first three months of this financial year has consistently been higher than the equivalent months in 2014/15 and based on this performance, there is a risk that we will not achieve the annual target of 12.00.The annual outturn for 2014/15 is 12.16; therefore we have not quite achieved the annual target of 12.00.

# Trust Dashboard Graphs for TRUST

## 18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind) | 55.32% | 66.39% | 83.33% | 83.33% | 81.82% | 79.31% | 44.44% | 68.18% | 14.29% | 25.00% |

### Narrative

The Trust position reported in June relates to May performance. The Trust position for May 2015 is 55.32% with 21 wards out of 47 wards surveyed in May not scoring higher than 80%. This is 19.68% below the target of 75.00% and a significant deterioration on April's position, reporting the lowest performance since the indicator was introduced in May 2014. North Yorkshire Locality (44.44%) and Forensics Services (14.29%) are failing to achieve target, accounting for 5 and 12 wards respectively. The Trust position for the financial year to date is 66.39%, which is 8.61% below target.

Surveys are reviewed within North Yorkshire on a monthly basis to try to identify any trends, but nothing has been identified to date. The position within Forensics is largely attributable to the low numbers of surveys that are being returned by patients. Furthermore given that the inherent nature of forensic patients being detained, it is less likely that that they will be positive about the experience on the ward.

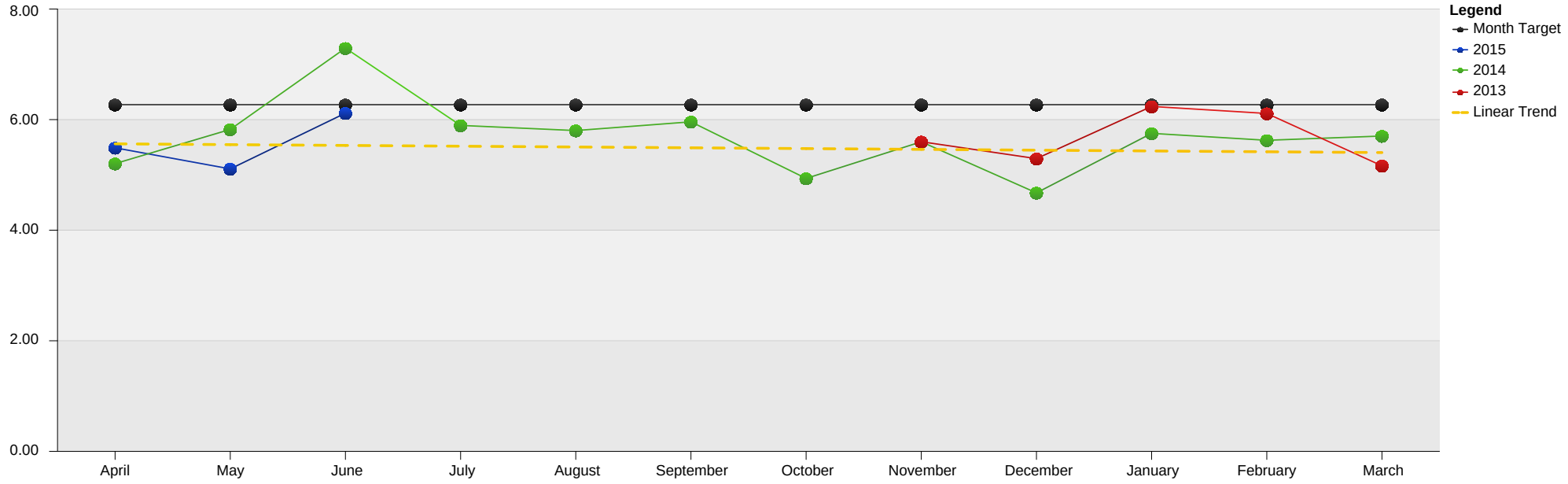
Based on past performance and June's performance, there is a risk that we will not achieve the annual target of 75% unless further action is taken.

As this indicator is reported a month behind, it must be noted the financial year will be calculated from March of the previous year to February within the current year (inclusive).

The annual outturn for 2014/15 was 73.17%.

# Trust Dashboard Graphs for TRUST

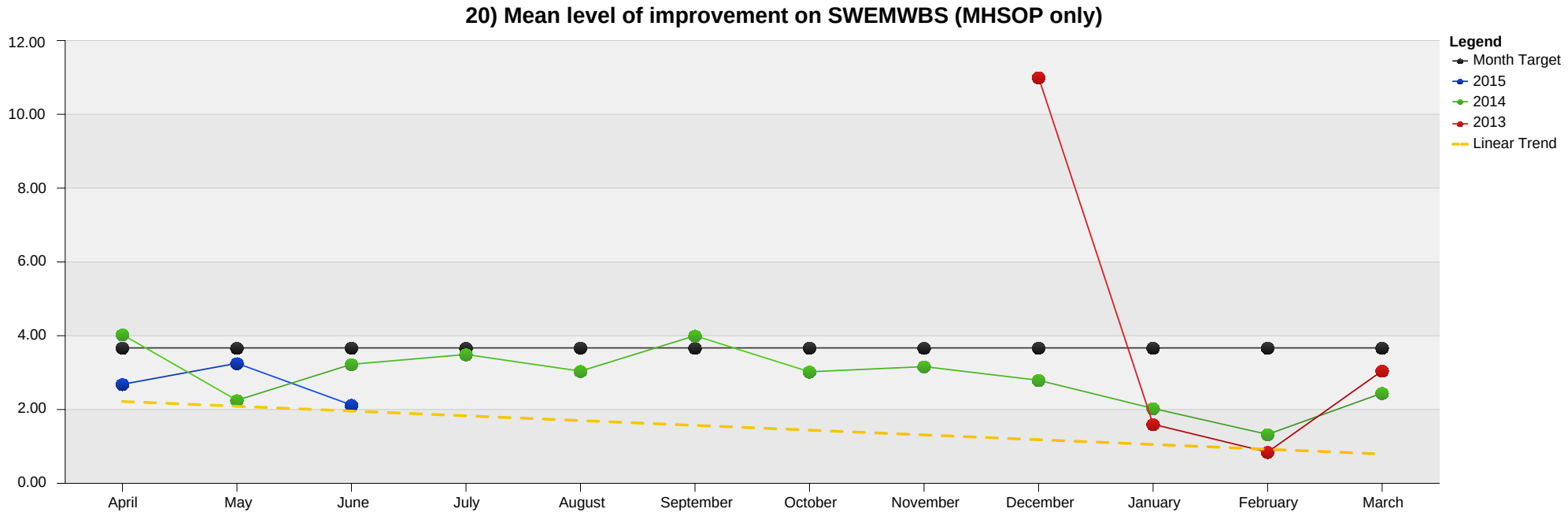
## 19) Mean level of improvement on SWEMWBS (AMH only)




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 19) Mean level of improvement on SWEMWBS (AMH only) | 6.12 | 5.62 | 6.20 | 5.49 | 6.33 | 5.23 | 5.76 | 6.26 | NA | NA |

| Narrative |
|---|
| The Trust position for June 2015 is 6.12 which is 0.15 below the target of 6.27 but an improvement on May performance. Only Teesside has achieved target in June. The Trust position for the financial year to date is 5.62, which is 0.65 below target.Based on past performance there is a risk that we will not achieve the annual target of 6.27; however, should the improvement reported during June continue the target can be achieved.The annual outturn for 2014/15 was 5.66. |

# Trust Dashboard Graphs for TRUST

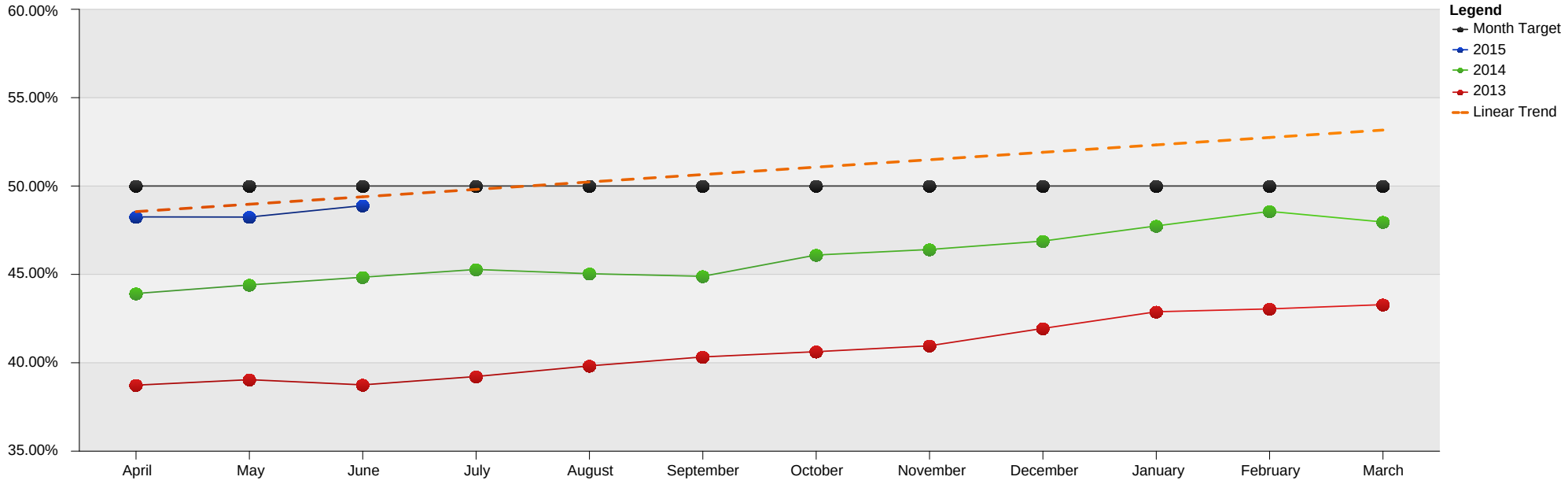



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 20) Mean level of improvement on SWEMWBS (MHSOP only) | 2.12 | 2.67 | 0.95 | 2.31 | 2.17 | 2.54 | 6.92 | 4.94 | NA | NA |

| Narrative |
|---|
| The Trust position for June 2015 is 2.12 which is 1.55 below the target of 3.67 and a deterioration on May performance and over the past 3 months. Only North Yorkshire has achieved target in June. The Trust position for the financial year to date is 2.67, which is 1.00 below target.Based on past performance and June's performance, there is a risk that we will not achieve the annual target of 3.52, unless further action is taken.The annual outturn for 2014/15 was 2.78. |

# Trust Dashboard Graphs for TRUST

## 21) HoNOS ratings that have improved in non-psychotic and psychosis superclass (AMH & MHSOP)

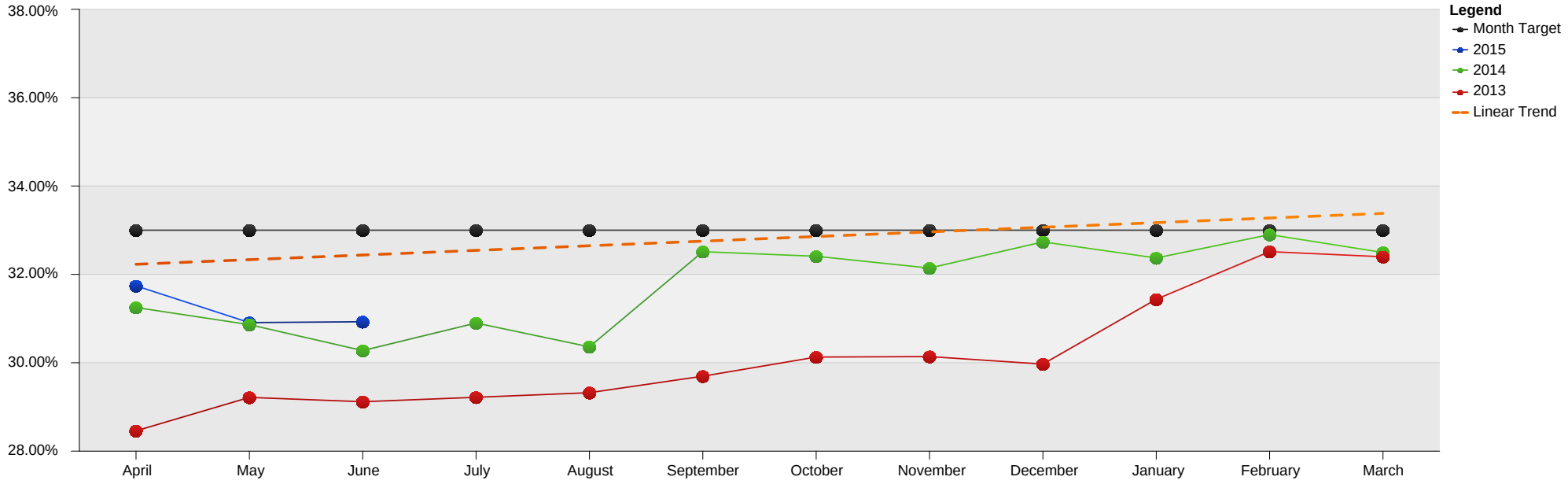



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 21) Percentage of HoNOS ratings that have improved in the non-psychotic and psychosis super classes for patients that are in scope (AMH and MHSOP) - snapshot | 48.89% | 48.89% | 43.84% | 43.84% | 53.69% | 53.69% | 51.98% | 51.98% | NA | NA |

| Narrative |
|---|
| The Trust position for June 2015 is 48.89% which is 1.11% below the target of 50% but a slight improvement on the May performance. Only Durham & Darlington is not achieving target. |
| Performance over the last three years has shown an increasing trend and should the improvement reported over the last three months be sustained it can be expected that we will achieve the annual target of 50%. |
| The annual outturn for 2014/15 was 43.92%. |

# Trust Dashboard Graphs for TRUST

## 22) HoNOS ratings that have improved in the organic superclass (AMH and MHSOP)

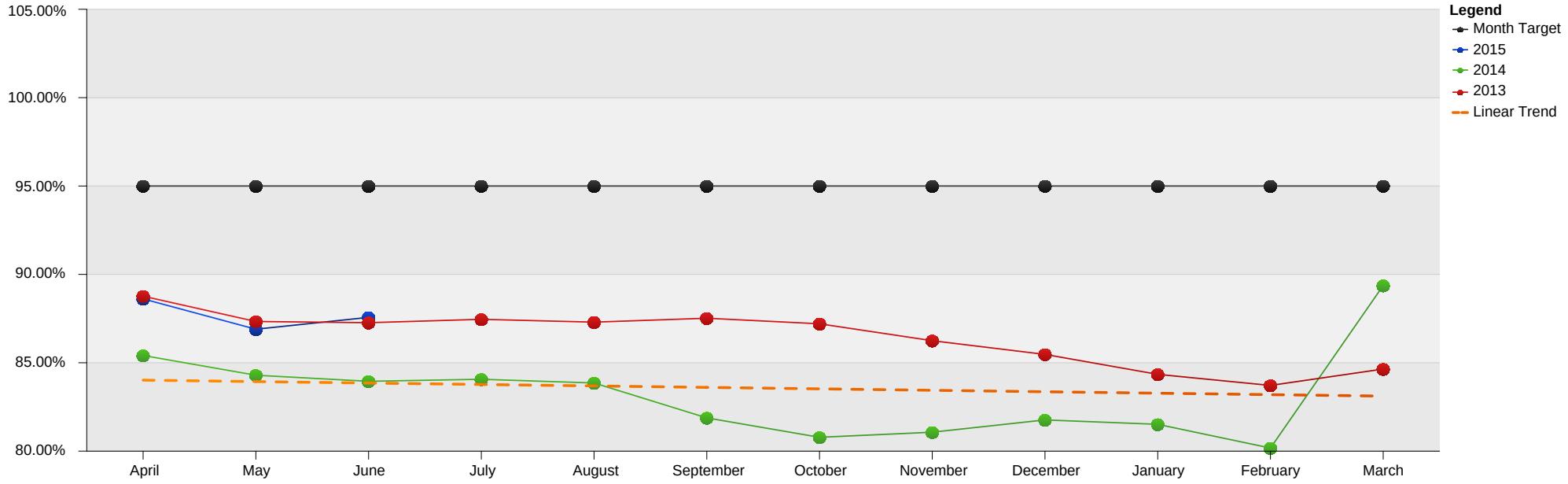



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 22) Percentage of HoNOS ratings that have improved in the organic super classes for patients that are in scope (AMH and MHSOP) - snapshot | 30.93% | 30.93% | 36.19% | 36.19% | 24.53% | 24.53% | 31.51% | 31.51% | NA | NA |

| Narrative |
|---|
| The Trust position for June 2015 is 30.93% which is 2.07% below the target of 33% but a very slight improvement on June performance. Only Durham & Darlington has achieved target in June.<br><br>Performance over the last three years has shown an increasing trend and historically this indicator has reported a dip at the start of the year and then a significant increase as the year progresses. Should this pattern continue, as indicated during the first three months of this financial year, it can be expected that we will achieve the annual target of 33%.<br><br>The annual outturn for 2014/15 was 31.25%. |

# Trust Dashboard Graphs for TRUST

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



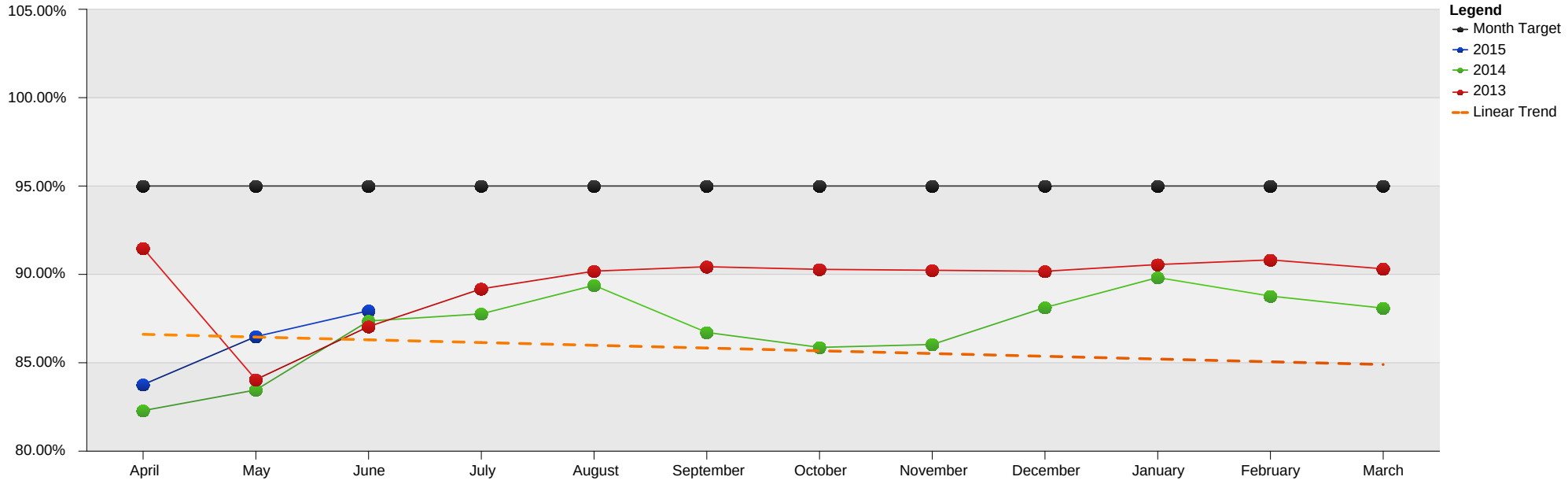

| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 23) Percentage of staff in post more than 12 months with a current appraisal (snapshot) | 87.57% | 87.57% | 86.92% | 86.92% | 87.89% | 87.89% | 86.32% | 86.32% | 90.36% | 90.36% |

**Narrative**

The Trust position for June 2015 is 87.57% which relates to 642 members of staff out of 5164 that do not have a current appraisal. This is 7.43% below the target of 95% but a slight improvement on the May 2015 position. 24 staff had their pay progression withheld at the end of June due to non-compliance of mandatory training and/or appraisal; this represents an increase on the number of 7 reported in May. Managers are able to access compliance reports through the IIC to monitor performance and a workshop is scheduled to take place in July to identify how the IIC can be utilised further to manage performance, the focus of which is to identify what a service/business manager would need to run their department/service effectively. A review of the reports currently produced has been undertaken and the event will help to identify ways to alert managers to areas of non-compliance and it is envisaged this will have a positive impact upon compliance rates.Based on past performance and June's performance, there is a risk that we will not achieve the annual target of 95%, unless further action is taken.The annual outturn for 2014/15 was 85.41%.

# Trust Dashboard Graphs for TRUST

## 24) Percentage compliance with mandatory and statutory training (snapshot)

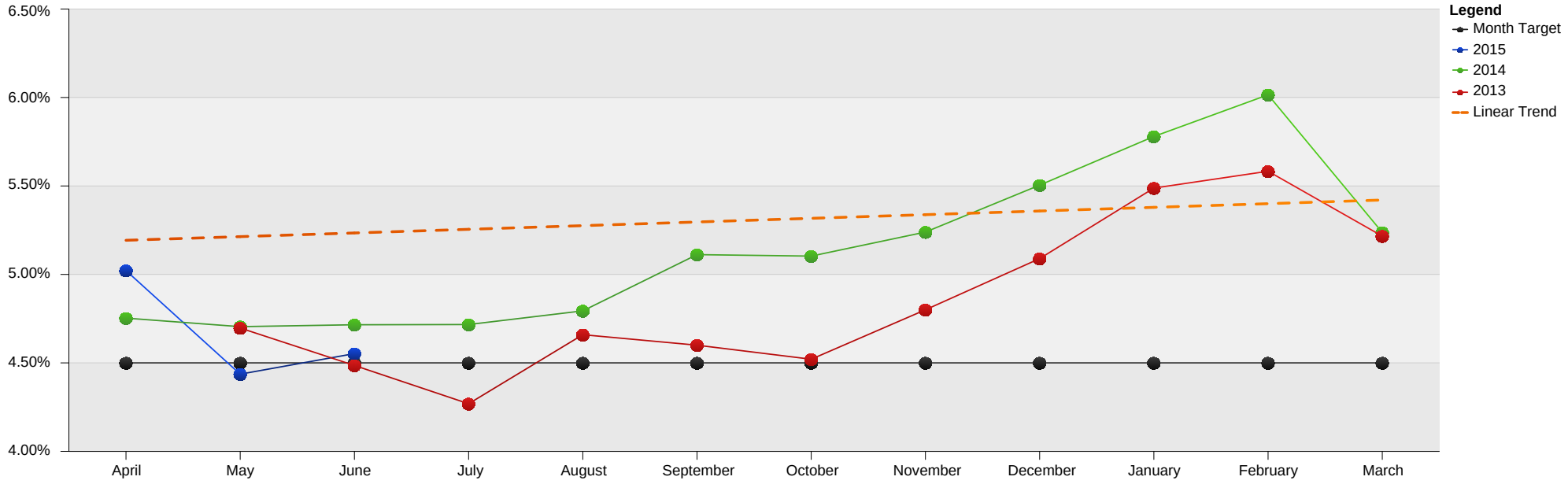



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 24) Percentage compliance with mandatory and statutory training (snapshot) | 87.94% | 87.94% | 87.01% | 87.01% | 88.58% | 88.58% | 83.81% | 83.81% | 88.67% | 88.67% |

| Narrative |
|---|
| The position for June 2015 is 87.94%. This is 7.06% below the target of 95% but an improvement on May 2015 performance.Regular monthly reports are produced for Heads of Service and line managers to monitor performance. It should be noted that Information Governance compliance is based on every member of staff turning red on 1st April each year. Information Governance compliance at the end of May showed that 4,602 staff (79.1%) had completed the training in the first quarter. Based on past performance and June's performance, there is a risk that we will not achieve the annual target of 95%, unless further action is taken.The annual outturn for 2014/15 was 82.29%. |

# Trust Dashboard Graphs for TRUST

## 25) Percentage Sickness Absence Rate (month behind)

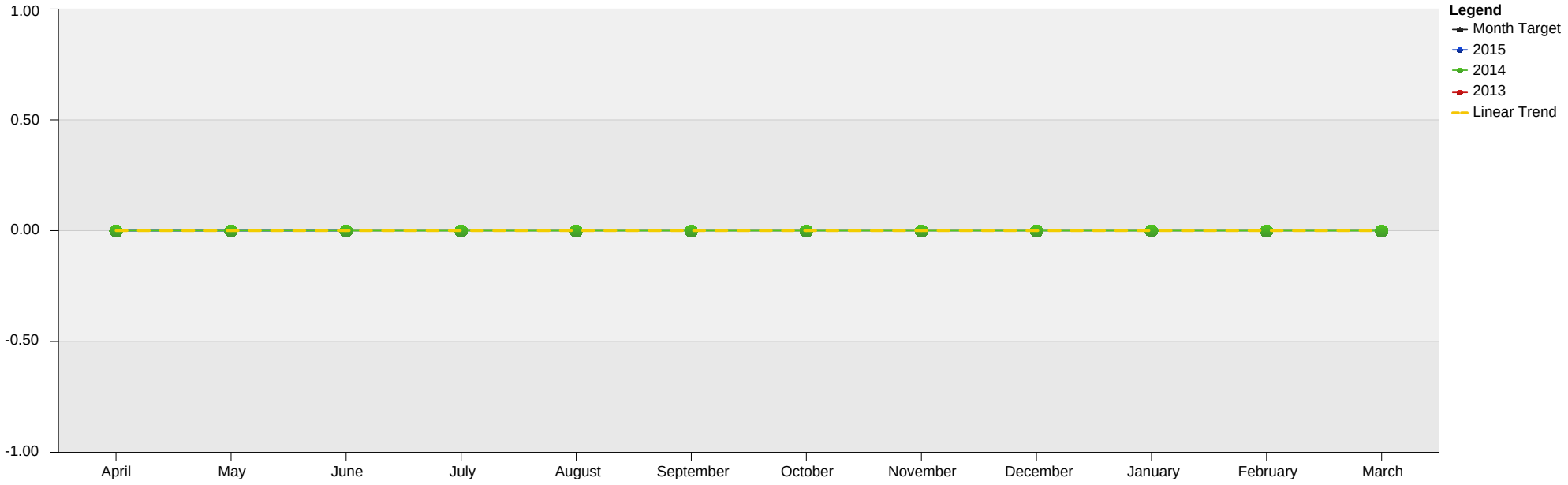



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 25) Percentage Sickness Absence Rate (month behind) | 4.55% | 4.67% | 4.22% | 4.58% | 4.97% | 5.08% | 4.38% | 4.52% | 6.44% | 6.31% |

| Narrative |
|---|
| The Trust position reported in June relates to the May sickness level. The Trust position reported in June 2015 is 4.55%, which is 0.05% above the Trust target of 4.50% and is a slight deterioration on the position reported in May. The Trust position for the financial year to date is 4.67%, which is 0.17% above target.A number of training events have taken place to inform managers about the revised Sickness Absence Management procedure and from July dual entry of sickness into ESR and Health Roster ceases.Based on past performance there is a risk that we will not achieve the annual target of 4.50%; however, a decreasing trend has been reported since February and should this improvement continue the target can be achieved.As this indicator is reported a month behind, it must be noted the financial year will be calculated from March of the previous year to February within the current year (inclusive).The annual outturn for 2014/15 was 5.12%. |

# Trust Dashboard Graphs for TRUST

## 26) Number of reds on CQC action plans (including MHA action plans)

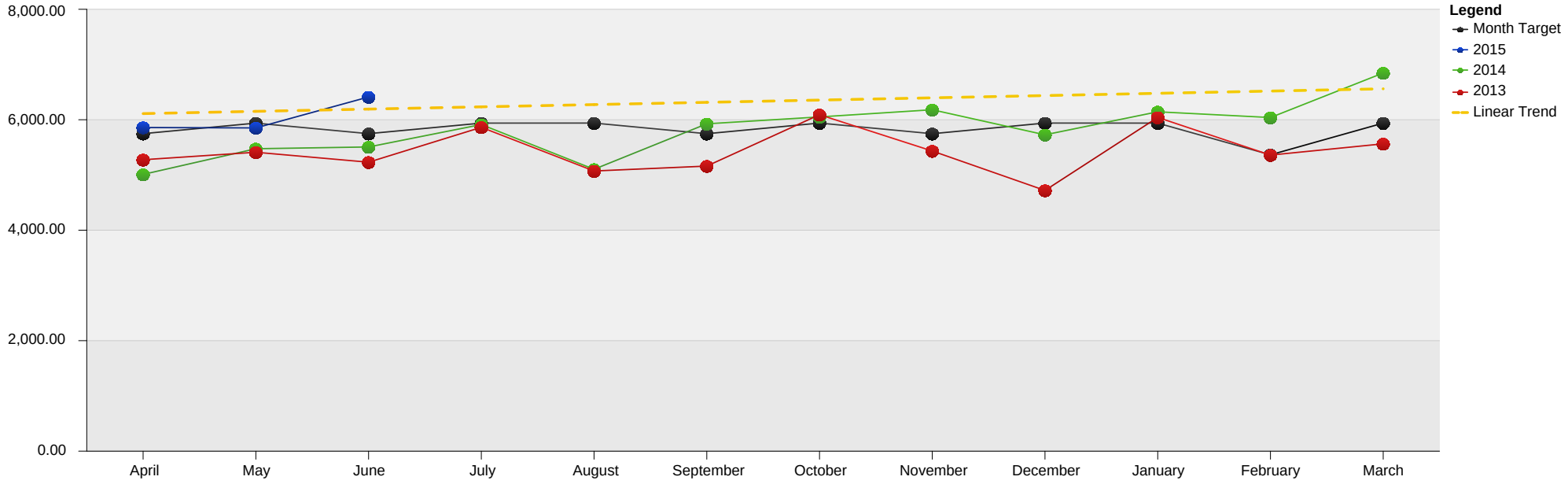



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 26) Number of reds on CQC action plans (including MHA action plans) | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

| Narrative |
|---|
| The Trust position for June 2015 is zero, which is consistent with 2014/15 reporting. |
| Based on past performance and June's performance, it is anticipated that we will achieve the annual target of 15%. |
| The annual outturn for 2014/15 was 0. |

# Trust Dashboard Graphs for TRUST

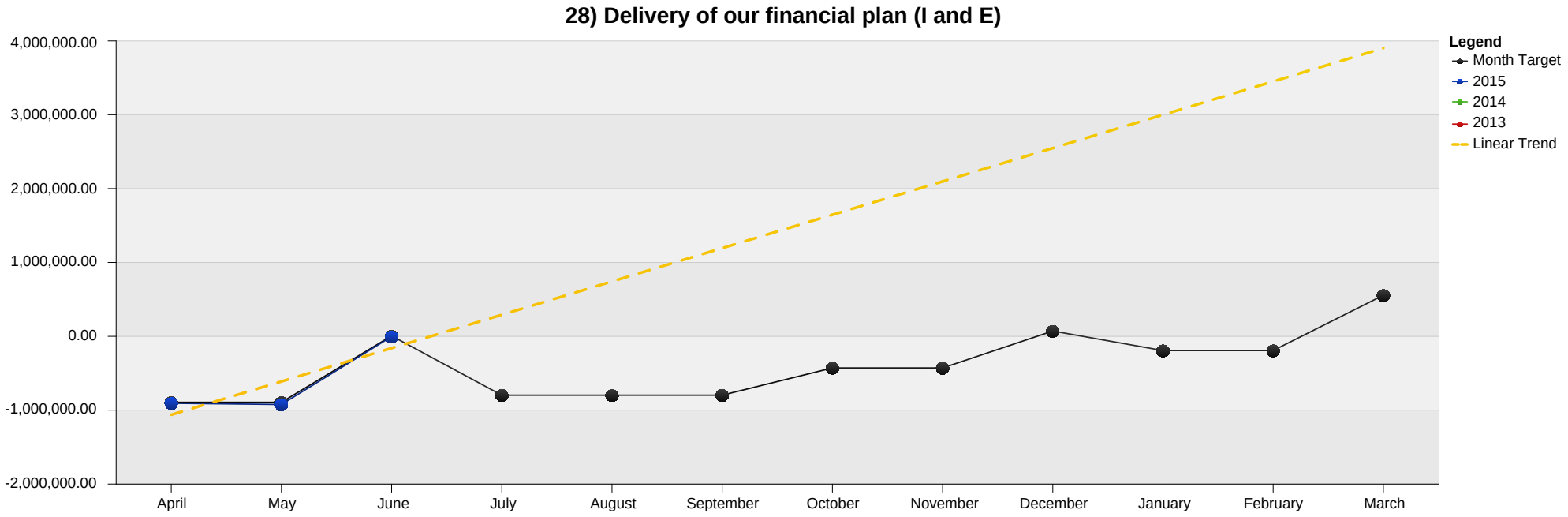
## 27) Total number of External Referrals into the Trust Services




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 27) Total number of External Referrals into the Trust Services | 6,412.00 | 18,123.00 | 1,986.00 | 5,785.00 | 2,116.00 | 6,077.00 | 1,871.00 | 5,389.00 | 439.00 | 870.00 |

| Narrative |
|---|
| The Trust position for June 2015 is 6412, which is 664 above the Trust target of 5748 and an increase on the number received in May. The Trust position for the financial year to date is 18,123, which is 688 above target.Performance over the last three years has shown an increasing trend as the year progresses. Should this pattern continue, as indicated during this financial year to date, it can be expected that we will receive more external referrals than the expected number of 69931.The annual outturn for 2014/15 was 69,920. |

# Trust Dashboard Graphs for TRUST




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 28) Delivery of our financial plan (I and E) | -4,000.00 | -1,834,000.00 | NA | NA | NA | NA | NA | NA | NA | NA |

| Narrative |
|---|
| The Trust position for June 2015 is a surplus of £4,000 which is £10,300 better that the expected deficit of £6,300. The Trust position for the financial year to date is a surplus of £1,834,000, which is £53,000 above target. |
| Based on performance during this financial year to date, it is anticipated that we will achieve the annual target of a surplus of £4,784,000. |
| Data only started to be collected from April 2015; therefore no comparative data for 2014/15 is available. |

## Trust Dashboard - Locality Breakdown for TRUST

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

| | June 2015 | | | | | | | | | | April 2015 To June 2015 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
| | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual |
| 1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral. | 98.00% | 80.42% | 98.00% | 78.26% | 98.00% | 85.08% | 98.00% | 73.85% | 98.00% | 100.00% | 98.00% | 80.99% | 98.00% | 78.96% | 98.00% | 86.66% | 98.00% | 73.51% | 98.00% | 99.77% |
| 2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral | 98.00% | 86.72% | 98.00% | 81.66% | 98.00% | 90.44% | 98.00% | 90.82% | 98.00% | 62.50% | 98.00% | 88.10% | 98.00% | 86.89% | 98.00% | 90.53% | 98.00% | 88.99% | 98.00% | 51.35% |
| 3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral. | 50.00% | 77.36% | 50.00% | 71.43% | 50.00% | 84.62% | 50.00% | 66.67% | NA | NA | 50.00% | 70.35% | 50.00% | 58.90% | 50.00% | 78.87% | 50.00% | 78.57% | NA | NA |
| 4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral. | 75.00% | 79.98% | 75.00% | 98.65% | 75.00% | 64.15% | 75.00% | 58.36% | NA | NA | 75.00% | 78.82% | 75.00% | 99.08% | 75.00% | 61.28% | 75.00% | 61.36% | NA | NA |
| 5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral. | 95.00% | 94.74% | 95.00% | 99.78% | 95.00% | 81.76% | 95.00% | 94.05% | NA | NA | 95.00% | 94.05% | 95.00% | 99.83% | 95.00% | 78.26% | 95.00% | 94.88% | NA | NA |
| 6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced) | 15.00% | 15.45% | 15.00% | 14.35% | NA | NA | 15.00% | 17.14% | NA | NA | 15.00% | 13.86% | 15.00% | 12.92% | NA | NA | 15.00% | 15.31% | NA | NA |
| 7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery | 50.00% | 46.47% | 50.00% | 42.34% | 50.00% | 47.33% | 50.00% | 53.22% | NA | NA | 50.00% | 46.88% | 50.00% | 43.85% | 50.00% | 49.23% | 50.00% | 49.74% | NA | NA |
| 8) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post-validated | 95.00% | 98.61% | 95.00% | 100.00% | 95.00% | 98.41% | 95.00% | 97.22% | NA | NA | 95.00% | 98.13% | 95.00% | 97.32% | 95.00% | 98.27% | 95.00% | 98.88% | NA | NA |
| 9) Percentage CPA 7 day follow up (AMH) - post-validated | 95.00% | 96.13% | 95.00% | 97.10% | 95.00% | 96.15% | 95.00% | 94.12% | NA | NA | 95.00% | 98.07% | 95.00% | 98.09% | 95.00% | 98.54% | 95.00% | 97.14% | NA | NA |
| 10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH) | 98.00% | 98.35% | 98.00% | 97.94% | 98.00% | 99.55% | 98.00% | 97.53% | 98.00% | | 98.00% | 98.35% | 98.00% | 97.94% | 98.00% | 99.55% | 98.00% | 97.53% | 98.00% | |
| 11) Percentage of community patients who state they have been involved in the development of their care plan (month behind) | 85.00% | 87.42% | 85.00% | 88.54% | 85.00% | 88.49% | 85.00% | 84.06% | 85.00% | 100.00% | 85.00% | 89.39% | 85.00% | 90.03% | 85.00% | 88.76% | 85.00% | 90.60% | 85.00% | 90.00% |

## Trust Dashboard - Locality Breakdown for TRUST

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

| | June 2015 | | | | | | | | | | April 2015 To June 2015 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
| | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual |
| 12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated | 15.00% | 14.96% | 15.00% | 15.53% | 15.00% | 4.60% | 15.00% | 28.12% | NA | NA | 15.00% | 17.17% | 15.00% | 17.47% | 15.00% | 6.23% | 15.00% | 31.89% | NA | NA |
| 13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) | 15.00% | 28.12% | 15.00% | 34.62% | 15.00% | 12.50% | 15.00% | 33.33% | NA | NA | 15.00% | 27.27% | 15.00% | 28.57% | 15.00% | 21.21% | 15.00% | 32.35% | NA | NA |
| 14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) | 17.00 | 20.00 | 5.00 | 9.00 | 5.00 | 4.00 | 7.00 | 6.00 | NA | NA | 52.00 | 69.00 | 16.00 | 25.00 | 16.00 | 19.00 | 20.00 | 24.00 | NA | NA |
| 15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP) | 146.00 | 108.00 | 146.00 | 94.00 | 146.00 | 485.00 | 146.00 | 52.00 | NA | NA | 146.00 | 98.00 | 146.00 | 108.50 | 146.00 | 133.00 | 146.00 | 79.00 | NA | NA |
| 16) Percentage of appointments cancelled by the Trust | 0.67% | 1.08% | 0.67% | 1.14% | 0.67% | 0.97% | 0.67% | 1.38% | 0.67% | 0.00% | 0.67% | 1.10% | 0.67% | 1.09% | 0.67% | 1.11% | 0.67% | 1.29% | 0.67% | 0.09% |
| 17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated | 1.00 | 1.64 | 1.00 | 1.58 | 1.00 | 2.43 | 1.00 | 0.82 | 1.00 | 0.00 | 3.00 | 4.73 | 3.00 | 3.94 | 3.00 | 4.88 | 3.00 | 6.49 | 3.00 | 0.00 |
| 18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind) | 75.00% | 55.32% | 75.00% | 83.33% | 75.00% | 81.82% | 75.00% | 44.44% | 75.00% | 14.29% | 75.00% | 66.39% | 75.00% | 83.33% | 75.00% | 79.31% | 75.00% | 68.18% | 75.00% | 25.00% |
| 19) Mean level of improvement on SWEMWBS (AMH only) | 6.27 | 6.12 | 6.27 | 6.20 | 6.27 | 6.33 | 6.27 | 5.76 | NA | NA | 6.27 | 5.62 | 6.27 | 5.49 | 6.27 | 5.23 | 6.27 | 6.26 | NA | NA |
| 20) Mean level of improvement on SWEMWBS (MHSOP only) | 3.67 | 2.12 | 3.67 | 0.95 | 3.67 | 2.17 | 3.67 | 6.92 | NA | NA | 3.67 | 2.67 | 3.67 | 2.31 | 3.67 | 2.54 | 3.67 | 4.94 | NA | NA |
| 21) Percentage of HoNOS ratings that have improved in the non-psychotic and psychosis super classes for patients that are in scope (AMH and MHSOP) - snapshot | 50.00% | 48.89% | 50.00% | 43.84% | 50.00% | 53.69% | 50.00% | 51.98% | NA | NA | 50.00% | 48.89% | 50.00% | 43.84% | 50.00% | 53.69% | 50.00% | 51.98% | NA | NA |
| 22) Percentage of HoNOS ratings that have improved in the organic super classes for patients that are in scope (AMH and MHSOP) - snapshot | 33.00% | 30.93% | 33.00% | 36.19% | 33.00% | 24.53% | 33.00% | 31.51% | NA | NA | 33.00% | 30.93% | 33.00% | 36.19% | 33.00% | 24.53% | 33.00% | 31.51% | NA | NA |

## Trust Dashboard - Locality Breakdown for TRUST

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

| | June 2015 | | | | | | | | | | April 2015 To June 2015 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
| | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual |
| 23) Percentage of staff in post more than 12 months with a current appraisal (snapshot) | 95.00% | 87.57% | 95.00% | 86.92% | 95.00% | 87.89% | 95.00% | 86.32% | 95.00% | 90.36% | 95.00% | 87.57% | 95.00% | 86.92% | 95.00% | 87.89% | 95.00% | 86.32% | 95.00% | 90.36% |
| 24) Percentage compliance with mandatory and statutory training (snapshot) | 95.00% | 87.94% | 95.00% | 87.01% | 95.00% | 88.58% | 95.00% | 83.81% | 95.00% | 88.67% | 95.00% | 87.94% | 95.00% | 87.01% | 95.00% | 88.58% | 95.00% | 83.81% | 95.00% | 88.67% |
| 25) Percentage Sickness Absence Rate (month behind) | 4.50% | 4.55% | 4.50% | 4.22% | 4.50% | 4.97% | 4.50% | 4.38% | 4.50% | 6.44% | 4.50% | 4.67% | 4.50% | 4.58% | 4.50% | 5.08% | 4.50% | 4.52% | 4.50% | 6.31% |

## Trust Dashboard - Locality Breakdown for TRUST

**Strategic Goal 5: To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve**

| | June 2015 | | | | | | | | | | April 2015 To June 2015 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
| | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual |
| 26) Number of reds on CQC action plans (including MHA action plans) | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| 27) Total number of External Referrals into the Trust Services | 5,748.00 | 6,412.00 | 1,876.00 | 1,986.00 | 1,921.00 | 2,116.00 | 1,767.00 | 1,871.00 | 183.00 | 439.00 | 17,435.00 | 18,123.00 | 5,692.00 | 5,785.00 | 5,827.00 | 6,077.00 | 5,360.00 | 5,389.00 | 555.00 | 870.00 |
| 28) Delivery of our financial plan (I and E) | 6,300.00 | -4,000.00 | NA | NA | NA | NA | NA | NA | NA | NA | -1,781,000.00 | -1,834,000.00 | NA | NA | NA | NA | NA | NA | NA | NA |

## MONITOR QUARTERLY SCORECARD - 2015/16

| Indicator | Target | Quarter 1 |
|---|---|---|
| Percentage CPA 7 day follow up (AMH only) (post validated position) | 95% | 98.07% |
| Percentage of CPA Patients having a formal review documented within 12 months (AMH only) | 95% | 98.35% |
| Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (AMH only) (post validated position) | 95% | 98.13% |
| Percentage of non acute patients whose transfer of care was delayed | 7.50% | 1.83% |
| Data completeness: outcomes | 90% | 94.36% |
| Data completeness: identifiers | 99% | 99.67% |
| Access to Healthcare | 100% | 100.00% |
| Number of EIP new cases | 100% | 261.54% |

Please note: the Q1 position is reported as at the 30th June 2015.

| | | Data Source | | | | | Data Reliability | | | | | KPI Construct/Definition | | | | | Total Score | Percentage as at December 2014* | Percentage | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A (5) | B (4) | C (3) | D (2) | E (1) | 5 | 4 | 3 | 2 | 1 | 5 | 4 | 3 | 2 | 1 | | | | |
| | | Direct Electronic transfer from System | Data extracted from Electronic System but data is then processed manually | Other Provider System | Access database or Excel Spreadsheet | Paper or telephone collection | Always reliable | Mostly reliable | Sometimes reliable | Unreliable | Untested Source | KPI is clearly defined | KPI is defined but could be open to interpretation | KPI is defined but is clearly open to interpretation | KPI construction is not clearly defined | KPI is not defined | | | | |
| 1 | Percentage of patients who have not waited longer than 4 weeks for a first appointment | 5 | | | | | | 4 | | | | 5 | | | | | 14 | 93% | 93% | |
| 2 | Percentage of patients who have not waited longer than 4 weeks following an internal referral | 5 | | | | | | 4 | | | | 5 | | | | | 14 | 93% | 93% | |
| 3 | Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral | 5 | | | | | | | 3 | | | 5 | | | | | 13 | n/a | 87% | The Trust have developed a local KPI pending publication of national construction. There is an issue identified with allocation of a care co-ordinator which was required for this indicator, this is being looked at through the Data Quality group, but has temporarily been removed from the logic. |
| 4 | Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral | | 4 | | | | | 4 | | | | 5 | | | | | 13 | n/a | 87% | |
| 5 | Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral | | 4 | | | | | 4 | | | | 5 | | | | | 13 | n/a | 87% | |
| 6 | Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced) | | 4 | | | | | 4 | | | | 5 | | | | | 13 | 87% | 87% | |
| 7 | Recovery Rate – Adult IAPT: The percentage of people who complete treatment who are moving to recovery | | 4 | | | | | 4 | | | | 5 | | | | | 13 | 87% | 87% | |
| 8 | Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) | | 4 | | | | | 4 | | | | 5 | | | | | 13 | 80% | 87% | Data is now imported back into IIC following manual validation. This increases reliability; however, there will be some discharges discounted because complete validation has not been possible within the time. These could subsequently be determined to be breaches. |
| 9 | Percentage CPA 7 day follow up (adult services only) | | 4 | | | | | 4 | | | | 5 | | | | | 13 | 80% | 87% | Data is now imported back into IIC following manual validation. This increases reliability; however, there will be some discharges discounted because complete validation has not been possible within the time. These could subsequently be determined to be breaches. |
| 10 | Percentage of CPA Patients having a formal review documented within 12 months – snapshot (adult services only) | 5 | | | | | | 4 | | | | 5 | | | | | 14 | 87% | 93% | |
| 11 | Percentage of community patients who state they have been involved in the development of their care plan (month behind) | | | | | 1 | | 4 | | | | 5 | | | | | 10 | 67% | 67% | Surveys are manual for community although some hand held for ALD. The surveys are sent to a team in Flatts Lane who input the scores from each paper survey into an excel spreadsheet. They send the spreadsheet to CRT who supply community based reports. The plan is to follow the same process as the ward from this point onwards. |
| 12 | Percentage of out of locality admissions to assessment and treatment wards (AMH and MHSOP) - post validated | | 4 | | | | | 4 | | | | 5 | | | | | 13 | n/a | 87% | |
| 13 | Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) | 5 | | | | | | 4 | | | | 5 | | | | | 14 | n/a | 93% | |
| 14 | Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) | 5 | | | | | 5 | | | | | 5 | | | | | 15 | n/a | 100% | |

| | | Data Source | | | | | Data Reliability | | | | | KPI Construct/Definition | | | | | Total Score | Percentage as at December 2014* | Percentage | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A (5) | B (4) | C (3) | D (2) | E (1) | 5 | 4 | 3 | 2 | 1 | 5 | 4 | 3 | 2 | 1 | | | | |
| | | Direct Electronic transfer from System | Data extracted from Electronic System but data is then processed manually | Other Provider System | Access database or Excel Spreadsheet | Paper or telephone collection | Always reliable | Mostly reliable | Sometimes reliable | Unreliable | Untested Source | KPI is clearly defined | KPI is defined but could be open to interpretation | KPI is defined but is clearly open to interpretation | KPI construction is not clearly defined | KPI is not defined | | | | |
| 15 | Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP) | 5 | | | | | 5 | | | | | 5 | | | | | 15 | n/a | 100% | |
| 16 | Percentage of appointments cancelled by the Trust | 5 | | | | | | | 3 | | | 5 | | | | | 13 | n/a | 87% | A number of data quality issues have been identified by the Patient Experience Group and the localities. A paper has been presented to the Data Quality Group and further work is being undertaken on this issue. |
| 17 | Number of unexpected deaths classed as a serious incident per 10,000 open cases | | | | | 1 | | 4 | | | | 5 | | | | | 10 | 60% | 67% | Different sources in calculation - lower one used which is a manual process including a telephone call and data entered onto a spreadsheet (unexpected deaths) |
| 18 | Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind) | | | 3 | | | | 4 | | | | 5 | | | | | 12 | 73% | 80% | Surveys for ward are via the hand held device. The devices are uploaded electronically (can sometimes be issues with the devices) direct to CRT. Patient Experience Team (PET) provided with ward based reports. PET open every ward report, identify the % and number completing. |
| 19 | Mean level of improvement on SWEMWBS (AMH Only) | 5 | | | | | 5 | | | | | 5 | | | | | 15 | 100% | 100% | |
| 20 | Mean level of improvement on SWEMWBS (MHSOP Only) | 5 | | | | | 5 | | | | | 5 | | | | | 15 | 100% | 100% | |
| 21 | Percentage HONOS ratings that have improved in the non-psychotic and psychosis super classes for patients that are in scope (AMH and MHSOP) | 5 | | | | | | 4 | | | | 5 | | | | | 14 | 93% | 93% | |
| 22 | Percentage of HONOS ratings that have improved in the organic super classes for patients that are in scope (AMH and MHSOP) | 5 | | | | | | 4 | | | | 5 | | | | | 14 | 93% | 93% | |
| 23 | Percentage of staff in post more than 12 months with a current appraisal – snapshot | 5 | | | | | | 4 | | | | 5 | | | | | 14 | 93% | 93% | |
| 24 | Percentage compliance with mandatory and statutory training – snapshot | 5 | | | | | | 4 | | | | 5 | | | | | 14 | 93% | 93% | |
| 25 | Percentage Sickness Absence Rate (month behind) | 5 | | | | | | | 3 | | | 5 | | | | | 13 | 87% | 87% | Audit findings have highlighted issues with the accuracy of data:<br>• Discrepancies between ESR and paper records<br>• Sickness periods not being recorded<br>• Sickness episodes not being closed |
| 26 | Number of reds on CQC Action Plans (including MHA Action Plans) | | | | | 1 | 5 | | | | | 5 | | | | | 11 | 67% | 73% | Static reports are emailed to the Trust. Data is then manually transferred from the reports into an Excel spreadsheet, which is then manually monitored to ensure all actions are green. |
| 27 | Total number of External Referrals into the Trust Services | 5 | | | | | 5 | | | | | 5 | | | | | 15 | 100% | 100% | |
| 28 | Are we delivering our financial plan (I and E) | | 4 | | | | 5 | | | | | 5 | | | | | 14 | n/a | 93% | |

* A comparative figure for December 2014 will only be available for those KPIs that were reported during the 2014/15 financial year

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

| | Number of unexpected deaths in the community | | | | Number of unexpected deaths of patients who are an inpatient and took place in the hospital | | | | Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital | | | | Number of unexpected deaths where the patient was no longer in service | | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Durham & Darlington | Teesside | North Yorkshire | Forensics | Durham & Darlington | Teesside | North Yorkshire | Forensics | Durham & Darlington | Teesside | North Yorkshire | Forensics | Durham & Darlington | Teesside | North Yorkshire | Forensics | |
| **Accidental death** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Natural causes** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Hanging** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Suicides** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Open** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Abuse of drugs** | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** |
| **Drowning** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Misadventure** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Awaiting verdict** | 9 | 4 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 2 | 1 | 0 | **24** |
| **Total** | **10** | **5** | **6** | **0** | **0** | **0** | **0** | **0** | **0** | **1** | **1** | **0** | **0** | **2** | **1** | **0** | **26** |

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

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

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

| | Number of unexpected deaths in the community | | | | Number of unexpected deaths of patients who are an inpatient and took place in the hospital | | | | Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital | | | | Number of unexpected deaths where the patient was no longer in service | | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Durham & Darlington | Teesside | North Yorkshire | Forensics | Durham & Darlington | Teesside | North Yorkshire | Forensics | Durham & Darlington | Teesside | North Yorkshire | Forensics | Durham & Darlington | Teesside | North Yorkshire | Forensics | |
| **Accidental death** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Natural causes** | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | **3** |
| **Hanging** | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | **4** |
| **Suicides** | 11 | 8 | 3 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 2 | 2 | 0 | **29** |
| **Open** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Abuse of drugs** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | **1** |
| **Drowning** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Misadventure** | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | **2** |
| **Awaiting verdict** | 8 | 2 | 4 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 3 | 2 | 0 | 0 | **22** |
| **Total** | **22** | **11** | **8** | **1** | **1** | **1** | **0** | **1** | **2** | **0** | **0** | **0** | **7** | **4** | **3** | **0** | **61** |

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

**FOR GENERAL RELEASE** **Item 15**

# BOARD OF DIRECTORS

**Date of Meeting:** 23rd July 2015
**Title:** Quarterly Workforce Report
**Lead Director:** Director of Human Resources and Organisational Development
**Report for:** Information

## This report includes/supports the following areas:

| STRATEGIC GOALS: | ✓ |
|---|---|
| To provide excellent services working with the individual users of our services and their carers to promote recovery and well being | |
| 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 our communities | |
| To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities | √ |

| CQC REGISTRATION: Outcomes (✓) | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | | Staffing | √ | Supporting workers | |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | √ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

# BOARD OF DIRECTORS

**Date of Meeting:** **23rd July 2015**

**Title:** **Quarterly Workforce Report**

## 1. INTRODUCTION & PURPOSE

1.1 The purpose of this report is to provide the Board of Directors with information concerning key workforce performance, primarily in respect of the period April to June 2015 (Appendix 1). Information about medical staffing issues is included (Appendix 2) as is a copy of the 2015/16 Q1 Staff Friends and Family Test results (Appendix 3).

## 2. BACKGROUND INFORMATION

2.1 The Quarterly Workforce Report is shared with the Executive Management Team, the Workforce and Development Group and the Joint Consultative Committee for information and to prompt debate and decision making.

## 3. KEY ISSUES:

3.1 The number of staff in post, the extent of use of fixed term contracts and the labour turnover rate remained largely unchanged compared to the previous quarter. Age retirement continues to be the largest single reason for staff leaving the Trust. Between 2016 and 2020 21% of the registered nurse workforce of the Trust, some 400 people, will reach 55 years of age, the normal pension age for those with mental health officer status. Almost one third of band 7 registered nurses, often ward and community team managers, will reach 55 years of age during this time. A range of local measures to help address the issue of the impact of an ageing workforce are being developed along with national initiatives.

3.2 Sickness absence levels have reduced compared to the previous quarter though they remain just above the Trust target rate. The level of sickness absence during 2014/15 equated to some 250 registered nurse posts being lost during the year. The scale and impact of sickness absence continues to be a concern and means that efforts to improve the health and wellbeing of Trust staff and to manage sickness absence more effectively will continue. The number of training sessions provided for managers concerning the revised Sickness Absence Management Procedure has been increased to ensure that there are more opportunities for managers to attend.

3.3 There has been a welcome improvement in the time taken to conclude disciplinary and grievance investigations though performance remains below target. The Executive Management Team recently agreed to establish a central investigation team with the aim of increasing the pace of disciplinary investigation completion and quality. The team is due to be established from October 2015. During the last four years 213 Trust staff have been dismissed, for a variety of reasons, and there have been on average seven employment tribunal claims registered by Trust, or ex-Trust,

employees per year. Some 60% of these claims have concerned dismissals. Of the 28 claims registered 10 have been settled, 8 have been withdrawn by claimants, 4 have been won by the Trust and 4 lost with 2 claims being struck out by the employment tribunal. Though the numbers of cases lodged, settled, won and lost have varied during each of the last four years these variations have not been significant.

3.4 Appraisal and mandatory training rates are below target though higher than for much of the last twelve months. It is clear that the changes made to the corporate induction programme in 2014 have had an adverse impact upon the number of new starters completing their mandatory training within 8 weeks of joining the Trust. Remedial measures are being pursued to help improve the position though should these efforts not be successful it will be necessary to review the corporate induction programme itself despite it having been very well evaluated since the changes made last year.

3.5 Average recruitment times are in line with targets though a number of recruitment episodes exceeded the target timescales. There is an increasing amount of evidence that recruitment to a greater range of posts is becoming more difficult than was previously the case. Examples include adult mental health posts in Durham and Darlington, older peoples service posts in North Yorkshire, learning disabilities service posts and nursing posts in Forensic services. These recruitment difficulties are in addition to those previously reported in respect of some medical staffing posts. The Quality Assurance Committee is to receive a detailed report about this matter at its October 2015 meeting.

3.6 The results of the Staff Friends and Family Test (Staff FFT) that was undertaken during the first quarter of 2015/16 are attached (Appendix 3). The responses to eight of the nine questions that are regularly asked were a little more positive than those given in the previous quarter. The number of staff, some 3,000, who continue to participate in the Staff FFT is encouraging. When compared to the Staff FFT results of the equivalent period last year the latest results do indicate that staff experience is improving overall though only by a few percentage points. This improvement is particularly welcome given feedback received about work pressures within the Trust. The intention is to produce and share the latest team based Staff FFT results over the coming weeks to encourage further consideration of ways in which to improve staff experience at work.

3.7 The Workforce Strategy scorecard position is as follows:

**Enabling involvement in decision making**

Year on year improvement in responses to the following annual staff survey and Staff FFT questions:

I am able to make suggestions to improve the work of my team/department – Staff FFT – Q1 2014/15 - 79% Q1 2015/16 – 81%

There are frequent opportunities for me to show initiative in my role – Staff FFT Q1 2014/15 – 74%  Q1 2015/16 – 77%

I am able to make improvements happen in my area of work – key Finding 22 of the annual staff opinion survey 2013 – 79%  2014 – 77%

**Delivering great management and leadership**

There are at least two TEWV candidates assessed as being 'above the line' for 66% or more of Band 7 posts that are recruited to where posts include people management responsibilities

June 2014 47%
September 2014 33%
December 2014 27%
March 2015– 23%

**Supporting training and development**

Year on year improvement in the annual staff survey key finding 6 score - % of staff saying that they have received job relevant training, learning or development in the last 12 months  2013 – 80%  2014 – 84%

**Ensuring every role counts**

Year on year improvements to the following annual staff opinion survey key findings:

% of staff agreeing that their role makes a difference to patients key finding 2 2013 – 915  2014 – 93%

% of staff appraised in the last 12 months key finding 7  2013 – 92%  2014 93%

% of staff having a well structured appraisal in last 12 months key finding 8 2013 – 52%  2014 - 49%

**Promoting health and wellbeing amongst our staff**

Achieve the annual Trust sickness absence target of less than 4.5% 2014/15 – 5.2%  2015/16 (YTD) – 4.6%

## 4. IMPLICATIONS / RISKS:

4.1 **Quality:** There is growing evidence that improving people management policy and practice can have a positive impact upon the quality of services provided.

4.2 **Financial:** None identified.

4.3 **Legal and Constitutional:** None identified.

4.4 **Equality and Diversity:** Each of the key workforce performance indicators requires that a positive approach is taken toward equality and diversity issues.

4.5 **Other Risks:** None identified.

## 5. CONCLUSIONS

5.1 A majority of the key workforce performance indicators show improvement compared to the previous quarter though most are below target. The latest Staff FFT results are encouraging.

5.2 A number of actions are being taken to improve performance including further work to better understand growing recruitment pressures to inform our response.

## 6. RECOMMENDATIONS

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

**David Levy**
**Director of Human Resources and Organisational Development**

**Background Papers:**

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

**APPENDIX 1**

# HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT DIRECTORATE

# QUARTERLY WORKFORCE REPORT KEY PERFORMANCE INDICATORS APRIL - JUNE 2015

## 1.0 INTRODUCTION

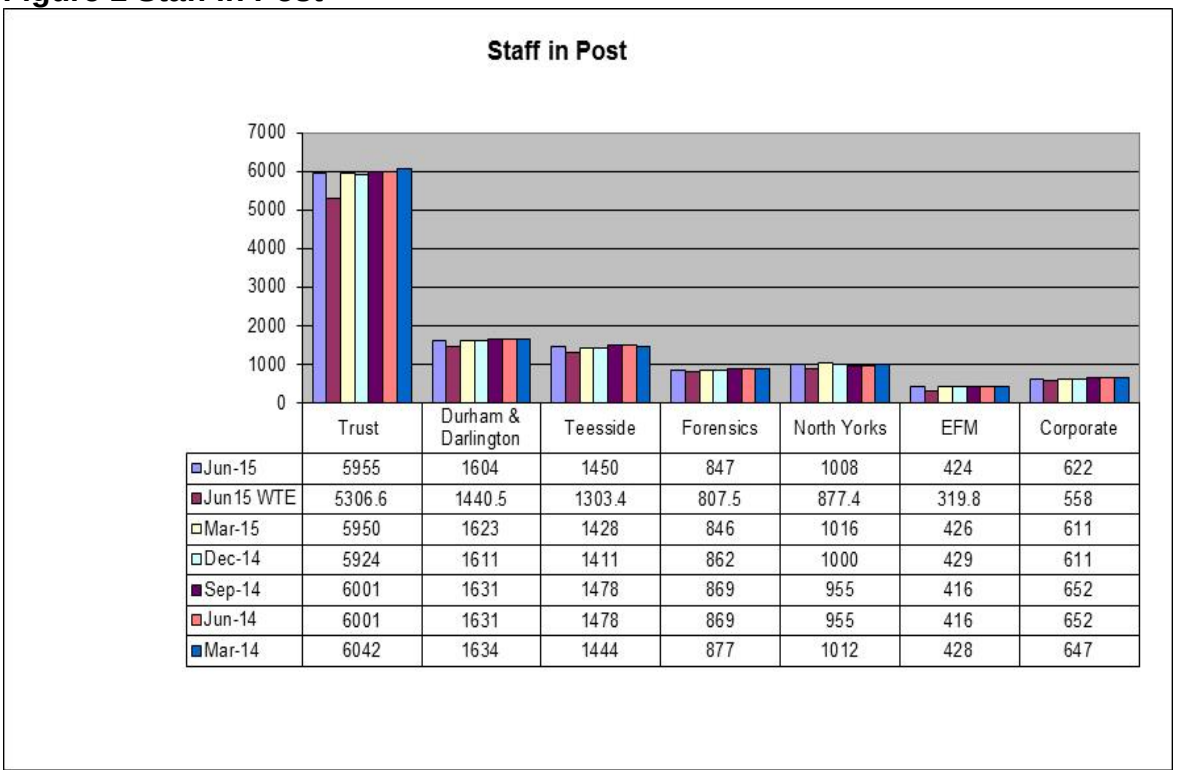
This report provides information about key workforce performance during the last quarter, April to June 2015.

## 2.0 Staff in Post

Figure 1 shows the staff in post position during the last quarter.

- The total Trust workforce has reduced by 0.76% over the last 12 months**.** In the last quarter the workforce has increased marginally by 5 to 5955.

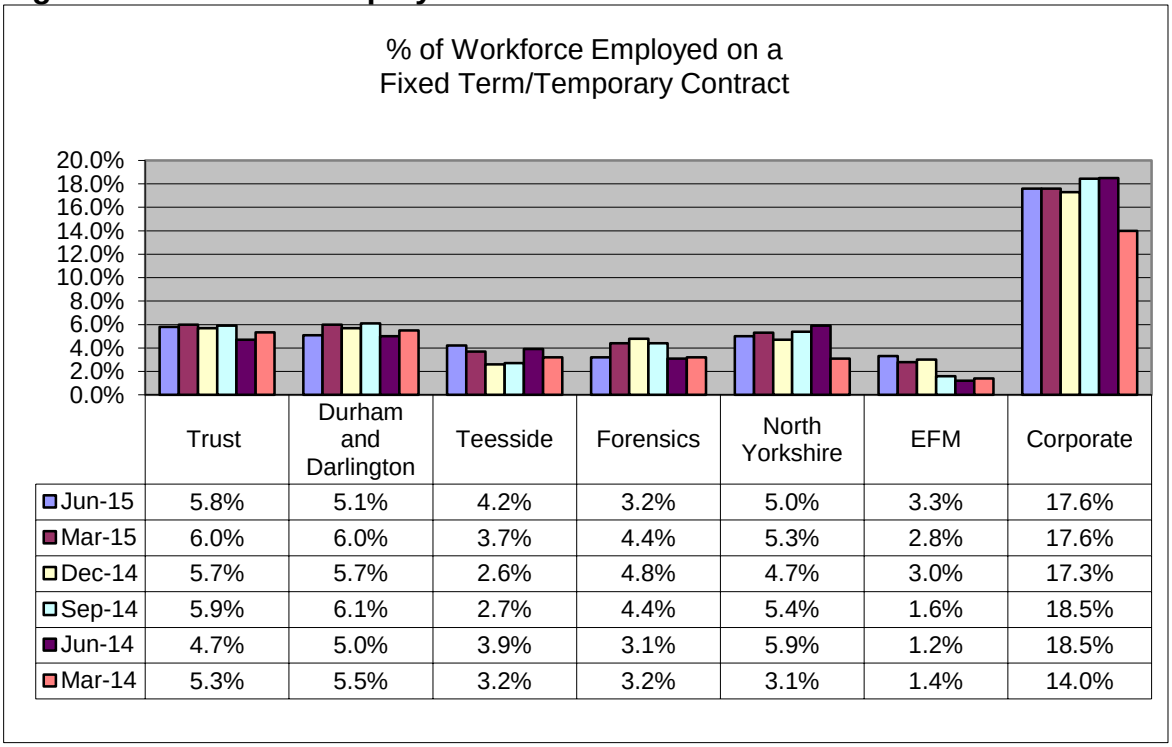
**Figure 1 Staff in Post**




| | Trust | Durham & Darlington | Teesside | Forensics | North Yorks | EFM | Corporate |
|---|---|---|---|---|---|---|---|
| Jun-15 | 5955 | 1604 | 1450 | 847 | 1008 | 424 | 622 |
| Jun15 WTE | 5306.6 | 1440.5 | 1303.4 | 807.5 | 877.4 | 319.8 | 558 |
| Mar-15 | 5950 | 1623 | 1428 | 846 | 1016 | 426 | 611 |
| Dec-14 | 5924 | 1611 | 1411 | 862 | 1000 | 429 | 611 |
| Sep-14 | 6001 | 1631 | 1478 | 869 | 955 | 416 | 652 |
| Jun-14 | 6001 | 1631 | 1478 | 869 | 955 | 416 | 652 |
| Mar-14 | 6042 | 1634 | 1444 | 877 | 1012 | 428 | 647 |

Figure 2 highlights the number of staff employed on a fixed term/temporary contract as a percentage of the total number of staff employed. Corporate Services continue to have the highest percentage of staff employed on a fixed term/temporary contract, due to the use of project-related posts.

## Figure 2 Fixed Term Employment

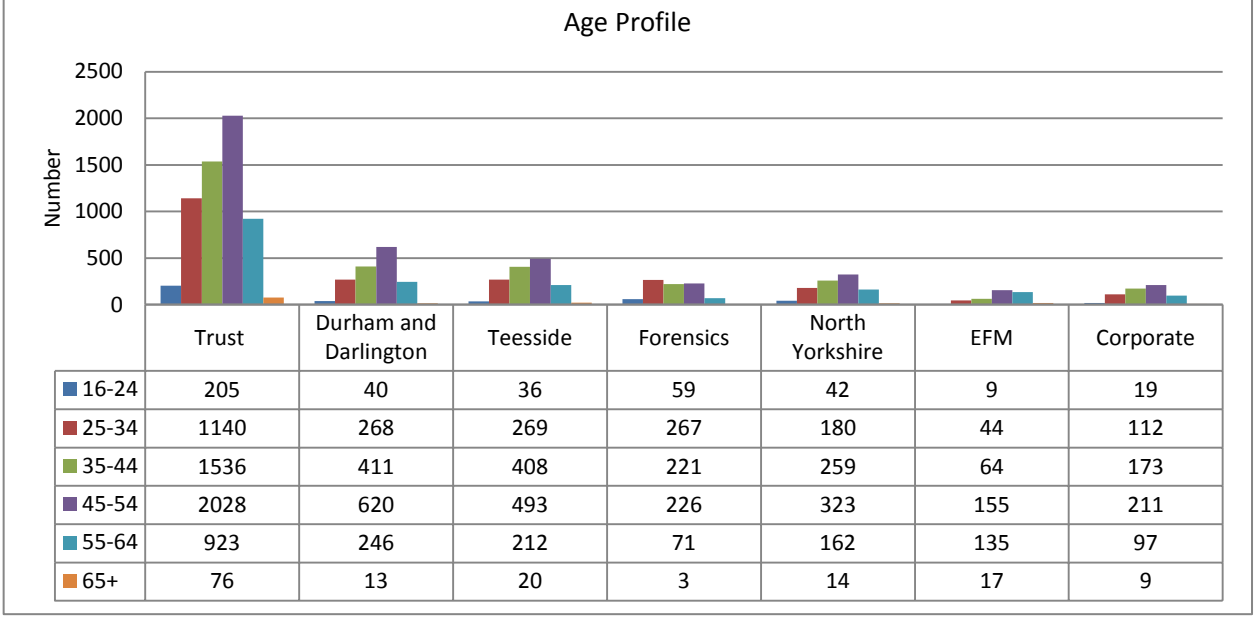



| | Trust | Durham and Darlington | Teesside | Forensics | North Yorkshire | EFM | Corporate |
|---|---|---|---|---|---|---|---|
| Jun-15 | 5.8% | 5.1% | 4.2% | 3.2% | 5.0% | 3.3% | 17.6% |
| Mar-15 | 6.0% | 6.0% | 3.7% | 4.4% | 5.3% | 2.8% | 17.6% |
| Dec-14 | 5.7% | 5.7% | 2.6% | 4.8% | 4.7% | 3.0% | 17.3% |
| Sep-14 | 5.9% | 6.1% | 2.7% | 4.4% | 5.4% | 1.6% | 18.5% |
| Jun-14 | 4.7% | 5.0% | 3.9% | 3.1% | 5.9% | 1.2% | 18.5% |
| Mar-14 | 5.3% | 5.5% | 3.2% | 3.2% | 3.1% | 1.4% | 14.0% |

- **figures exclude doctors in training and trainee clinical psychologists**

Figure 3 highlights the age profile of the Trust. Analysis shows 50.8% of staff aged between 44 and over 65. This trend is comparable within Teesside, North Yorkshire Localities and Corporate Services. The figure increases to 54.8% in Durham and Darlington and is considerably lower in Forensic Services at 35.1%. The figure is significantly higher in Estates and Facilities Management at 72.4%

## Figure 3 Age Profile

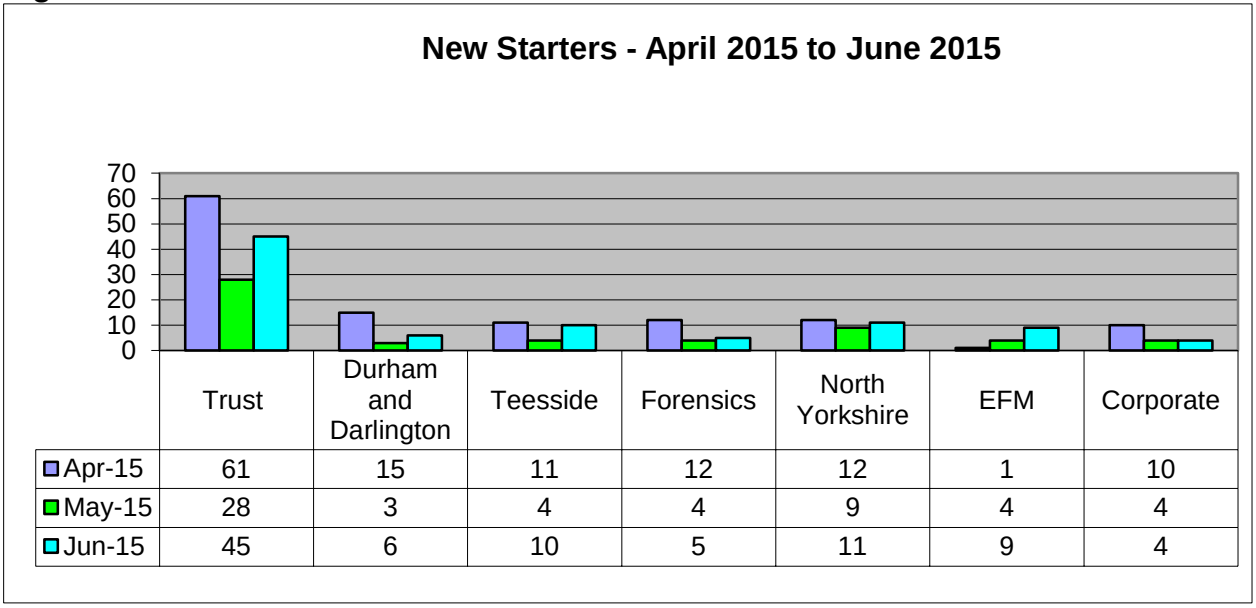



| | Trust | Durham and Darlington | Teesside | Forensics | North Yorkshire | EFM | Corporate |
|---|---|---|---|---|---|---|---|
| 16-24 | 205 | 40 | 36 | 59 | 42 | 9 | 19 |
| 25-34 | 1140 | 268 | 269 | 267 | 180 | 44 | 112 |
| 35-44 | 1536 | 411 | 408 | 221 | 259 | 64 | 173 |
| 45-54 | 2028 | 620 | 493 | 226 | 323 | 155 | 211 |
| 55-64 | 923 | 246 | 212 | 71 | 162 | 135 | 97 |
| 65+ | 76 | 13 | 20 | 3 | 14 | 17 | 9 |

## 4.0 New Starters

Figure 4 highlights the number of new starters within the Trust during the last quarter. There were a total of 134 new starters during the quarter compared to 169 reported in the previous quarter.

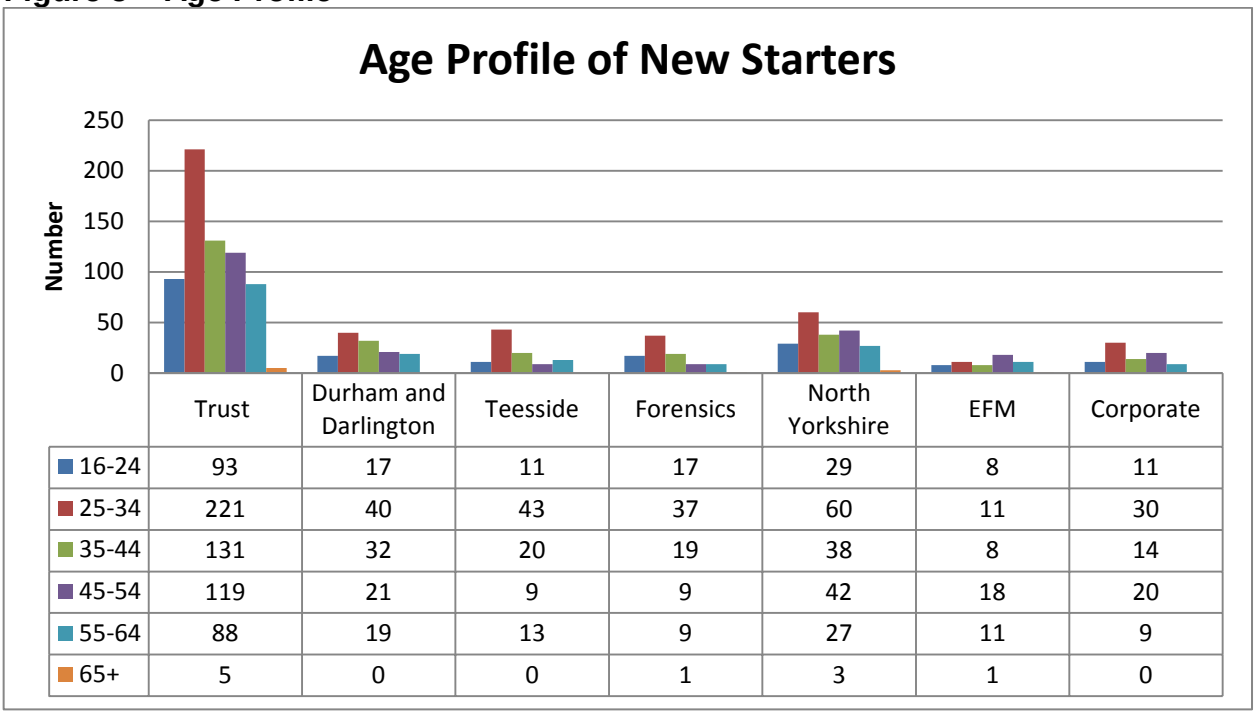
**Figure 4 New Starters**




| | Trust | Durham and Darlington | Teesside | Forensics | North Yorkshire | EFM | Corporate |
|---|---|---|---|---|---|---|---|
| Apr-15 | 61 | 15 | 11 | 12 | 12 | 1 | 10 |
| May-15 | 28 | 3 | 4 | 4 | 9 | 4 | 4 |
| Jun-15 | 45 | 6 | 10 | 5 | 11 | 9 | 4 |

Figures 5 shows an age profile of new starters over the last 12 months. Analysis highlights that 33.6% of new starters are aged between 25 and 34. This figures increases to 44.8% for Teesside and 40.2% in Forensic Services. Estates and Facilities Management show 31.6% of new starters within the age range 45 – 54.

**Figure 5 – Age Profile**

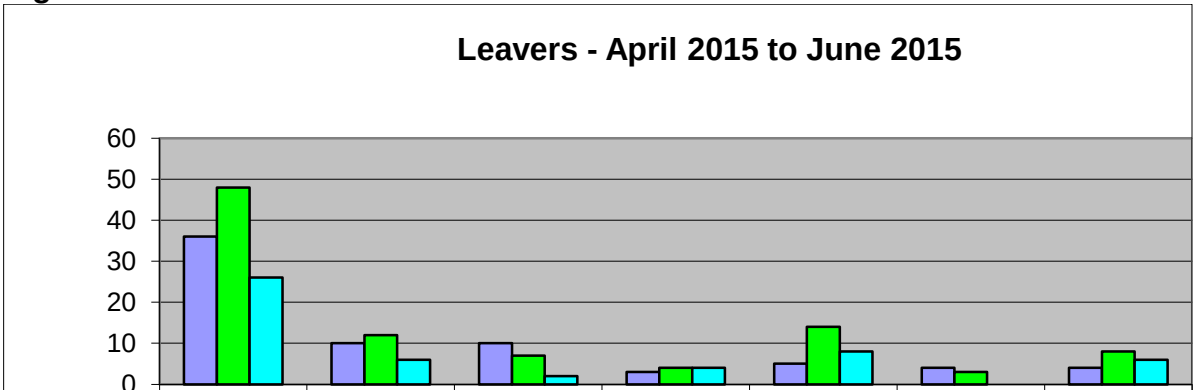



| | Trust | Durham and Darlington | Teesside | Forensics | North Yorkshire | EFM | Corporate |
|---|---|---|---|---|---|---|---|
| 16-24 | 93 | 17 | 11 | 17 | 29 | 8 | 11 |
| 25-34 | 221 | 40 | 43 | 37 | 60 | 11 | 30 |
| 35-44 | 131 | 32 | 20 | 19 | 38 | 8 | 14 |
| 45-54 | 119 | 21 | 9 | 9 | 42 | 18 | 20 |
| 55-64 | 88 | 19 | 13 | 9 | 27 | 11 | 9 |
| 65+ | 5 | 0 | 0 | 1 | 3 | 1 | 0 |

## 5.0 Leavers

Figure 6 shows the number of leavers during the last quarter.

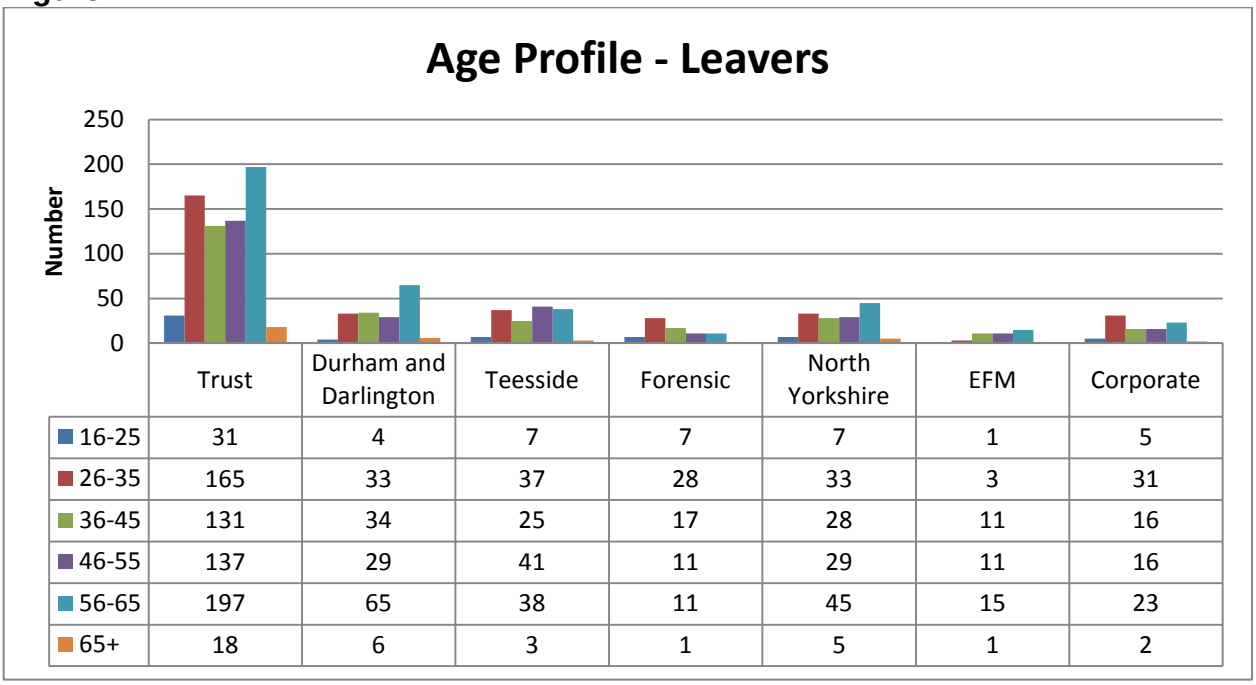
**Figure 6 Leavers**




| | Trust | Durham and Darlington | Teesside | Forensics | North Yorkshire | EFM | Corporate |
|---|---|---|---|---|---|---|---|
| Apr-15 | 36 | 10 | 10 | 3 | 5 | 4 | 4 |
| May-15 | 48 | 12 | 7 | 4 | 14 | 3 | 8 |
| Jun-15 | 26 | 6 | 2 | 4 | 8 | 0 | 6 |

Figures 7 shows an age profile of leavers over the last 12 months. Analysis highlights that 29.0% of leavers were aged between 56 and 65. This figure increases to 38.0% in Durham and Darlington Locality.

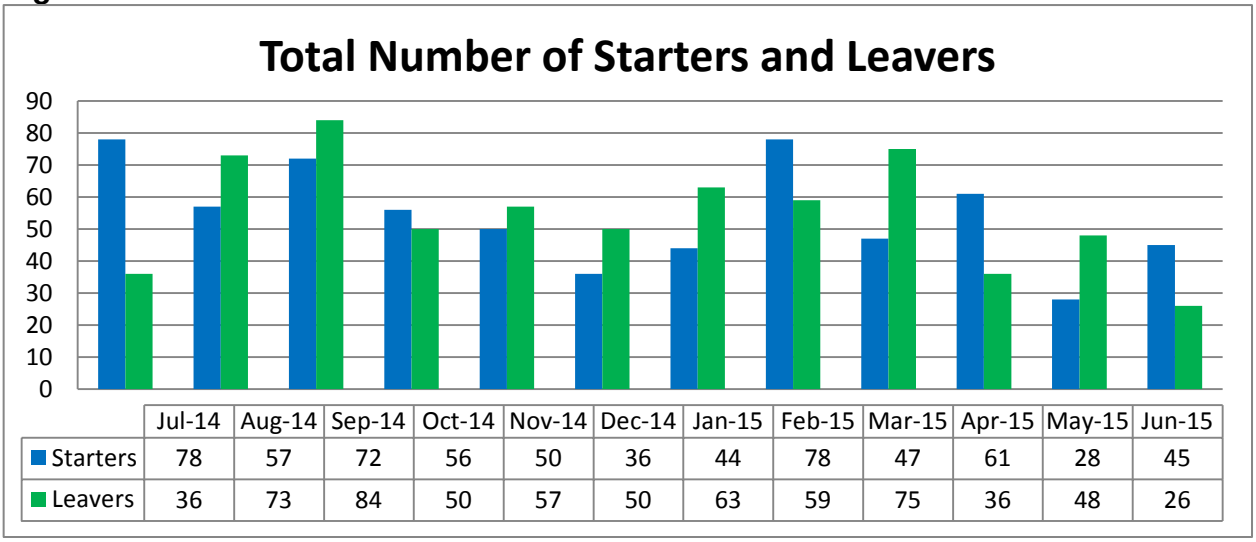
**Figure7**




| | Trust | Durham and Darlington | Teesside | Forensic | North Yorkshire | EFM | Corporate |
|---|---|---|---|---|---|---|---|
| 16-25 | 31 | 4 | 7 | 7 | 7 | 1 | 5 |
| 26-35 | 165 | 33 | 37 | 28 | 33 | 3 | 31 |
| 36-45 | 131 | 34 | 25 | 17 | 28 | 11 | 16 |
| 46-55 | 137 | 29 | 41 | 11 | 29 | 11 | 16 |
| 56-65 | 197 | 65 | 38 | 11 | 45 | 15 | 23 |
| 65+ | 18 | 6 | 3 | 1 | 5 | 1 | 2 |

Figure 8 shows the total number of starters and leavers during the period April 2014 to March 2015. The average number of starters over the last 12 month period has remained at 54 per month. The average number of leavers over the last 12 month period has also reduced to 55 per month.

**Figure 8 New Starters and Leavers Numbers**



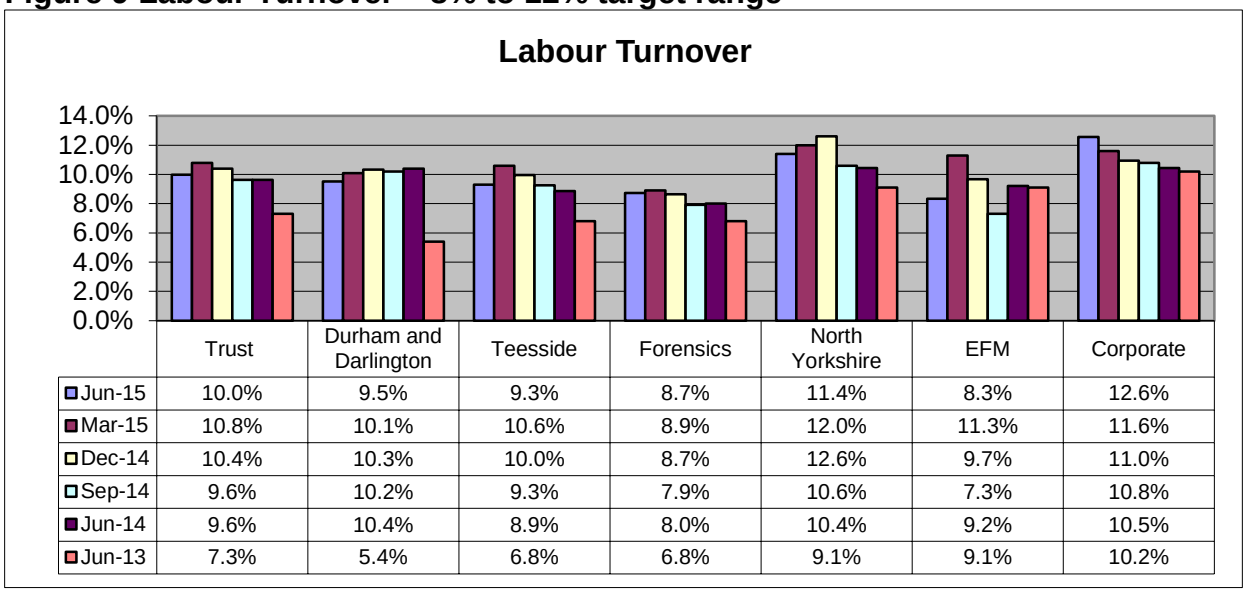

| | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Jan-15 | Feb-15 | Mar-15 | Apr-15 | May-15 | Jun-15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Starters | 78 | 57 | 72 | 56 | 50 | 36 | 44 | 78 | 47 | 61 | 28 | 45 |
| Leavers | 36 | 73 | 84 | 50 | 57 | 50 | 63 | 59 | 75 | 36 | 48 | 26 |

## 6.0 Labour Turnover

Figure 9 provides information about labour turnover rates up to 30th June 2015. A total of 595 staff left the Trust during the last 12 months. The calculation **excludes doctors in training** that have left the Trust.

- 94 leavers were employed on a fixed term contract when their **employment with the Trust ended.**
- The Trust turnover rate falls to 8.4% when fixed term contract leavers are excluded from the labour turnover calculation.
- 41 members of staff chose to retire flexibly and return to the Trust after the requisite break in service. The Flexible Retirement Scheme allows staff to access their pension at a reduced rate and return to work part time.
- 100 members of staff left for reason of age related retirement and 14 voluntarily retired early.

**Figure 9 Labour Turnover – 8% to 12% target range**




| | Trust | Durham and Darlington | Teesside | Forensics | North Yorkshire | EFM | Corporate |
|---|---|---|---|---|---|---|---|
| Jun-15 | 10.0% | 9.5% | 9.3% | 8.7% | 11.4% | 8.3% | 12.6% |
| Mar-15 | 10.8% | 10.1% | 10.6% | 8.9% | 12.0% | 11.3% | 11.6% |
| Dec-14 | 10.4% | 10.3% | 10.0% | 8.7% | 12.6% | 9.7% | 11.0% |
| Sep-14 | 9.6% | 10.2% | 9.3% | 7.9% | 10.6% | 7.3% | 10.8% |
| Jun-14 | 9.6% | 10.4% | 8.9% | 8.0% | 10.4% | 9.2% | 10.5% |
| Jun-13 | 7.3% | 5.4% | 6.8% | 6.8% | 9.1% | 9.1% | 10.2% |

***figures exclude doctors in training.

The table below highlights analysis undertaken in to the **most prevalent reasons** for leaving the Trust over the last 12 months. The analysis excludes doctors in training and staff leaving with a reason of end of fixed term contract.

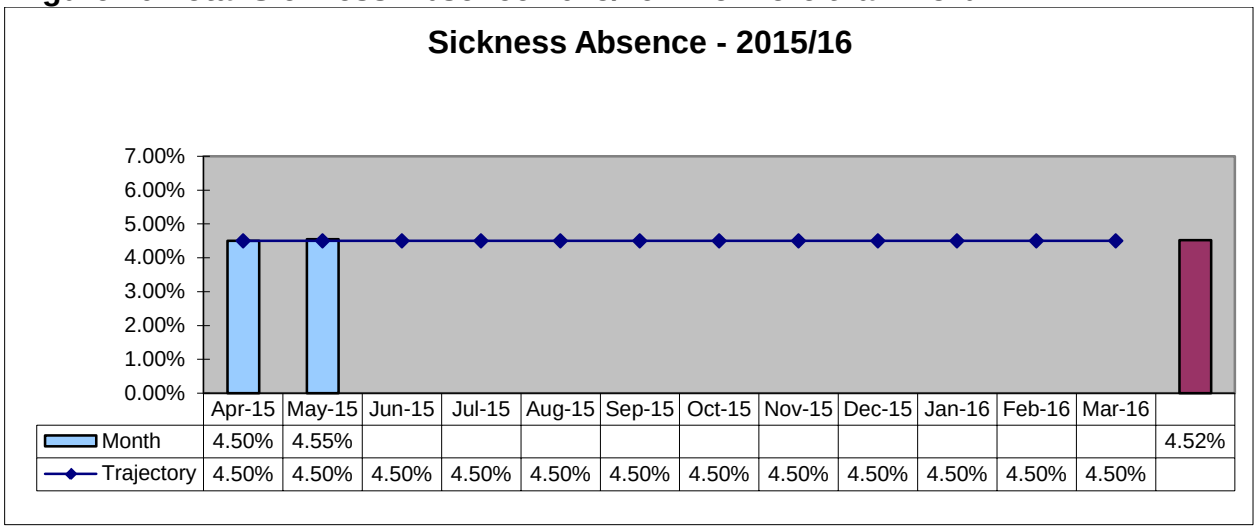
| | Trust | Durham & Darlington | Teesside | Forensics | North Yorkshire | EFM | Corporate |
|---|---|---|---|---|---|---|---|
| **Number of leavers** | 501 | 138 | 124 | 67 | 101 | 29 | 43 |
| **Age retirement** | 20.5% | 30.4% | 17.7% | 3.0% | 21.7% | 20.6% | 20.9% |
| **Voluntary resignation – Other/ unknown** | 17.1% | 10.1% | 16.9% | 35.8% | 16.8% | 20.6% | 9.3% |
| **Voluntary resignation -relocation** | 12.0% | 10.8% | 8.1% | 16.4% | 17.8% | 10.3% | 7.0% |
| **Voluntary resignation -promotion** | 8.0% | 7.2% | 7.3% | 7.5% | 8.9% | 0.0% | 16.3% |
| **Voluntary resignation – work-life balance** | 5.4% | 3.6% | 4.8% | 4.5% | 7.0% | 10.3% | 7.0% |

The average length of service of staff leaving the Trust is 9 years.

## 7.0 Sickness Absence

Figure 10 provides details of performance compared to target

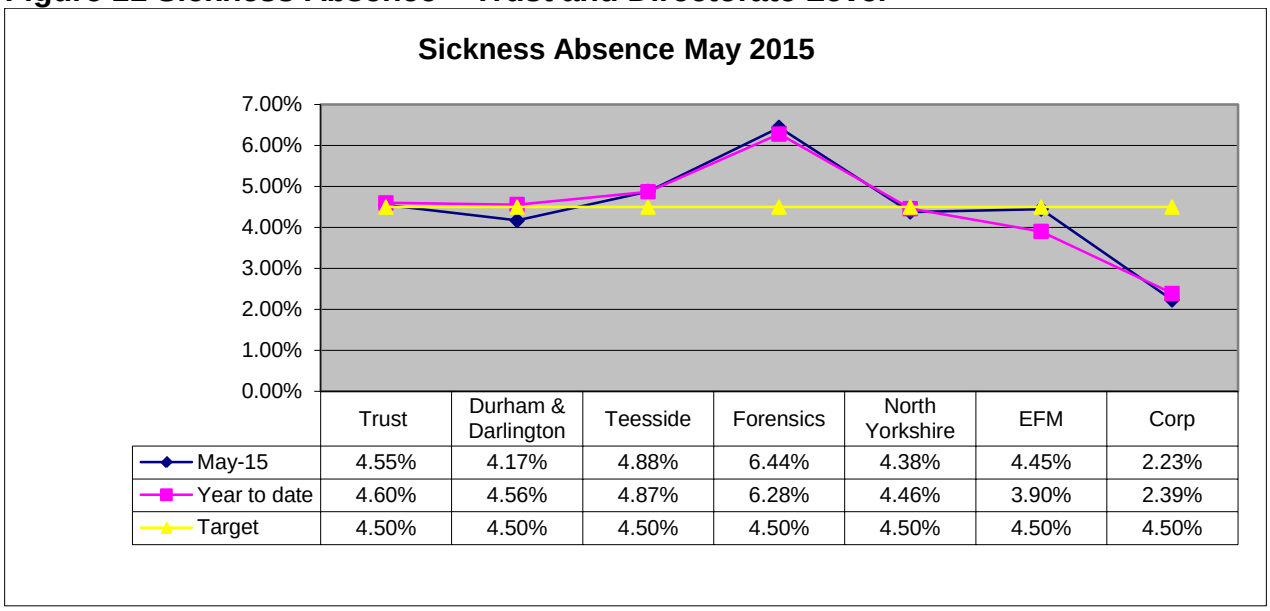
**Figure 10 Total Sickness Absence 2015/16 – no more than 4.5%**




| | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Month | 4.50% | 4.55% | | | | | | | | | | | 4.52% |
| Trajectory | 4.50% | 4.50% | 4.50% | 4.50% | 4.50% | 4.50% | 4.50% | 4.50% | 4.50% | 4.50% | 4.50% | 4.50% | |

Figure 11 provides sickness absence percentage rate information at Trust and directorate level. Variations between directorate rates are apparent.

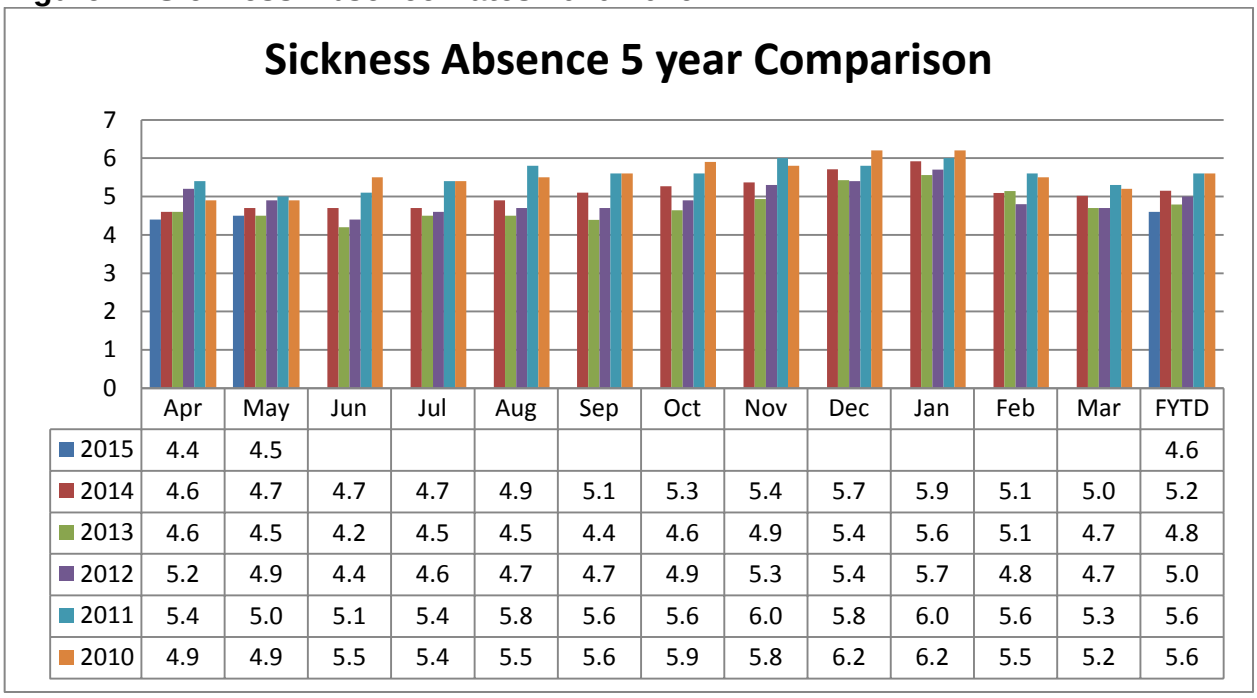
**Figure 11 Sickness Absence – Trust and Directorate Level**




| | Trust | Durham & Darlington | Teesside | Forensics | North Yorkshire | EFM | Corp |
|---|---|---|---|---|---|---|---|
| May-15 | 4.55% | 4.17% | 4.88% | 6.44% | 4.38% | 4.45% | 2.23% |
| Year to date | 4.60% | 4.56% | 4.87% | 6.28% | 4.46% | 3.90% | 2.39% |
| Target | 4.50% | 4.50% | 4.50% | 4.50% | 4.50% | 4.50% | 4.50% |

Figure 12 includes monthly sickness absence rates over the last five years.

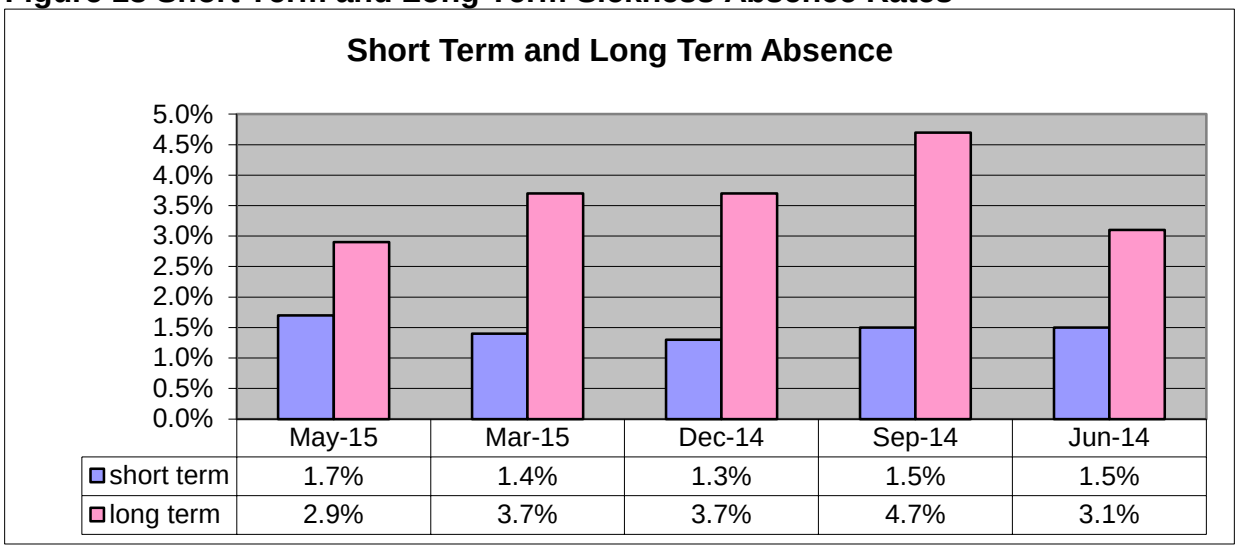
**Figure 12 Sickness Absence Rates 2010-2016**




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | FYTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015 | 4.4 | 4.5 | | | | | | | | | | | 4.6 |
| 2014 | 4.6 | 4.7 | 4.7 | 4.7 | 4.9 | 5.1 | 5.3 | 5.4 | 5.7 | 5.9 | 5.1 | 5.0 | 5.2 |
| 2013 | 4.6 | 4.5 | 4.2 | 4.5 | 4.5 | 4.4 | 4.6 | 4.9 | 5.4 | 5.6 | 5.1 | 4.7 | 4.8 |
| 2012 | 5.2 | 4.9 | 4.4 | 4.6 | 4.7 | 4.7 | 4.9 | 5.3 | 5.4 | 5.7 | 4.8 | 4.7 | 5.0 |
| 2011 | 5.4 | 5.0 | 5.1 | 5.4 | 5.8 | 5.6 | 5.6 | 6.0 | 5.8 | 6.0 | 5.6 | 5.3 | 5.6 |
| 2010 | 4.9 | 4.9 | 5.5 | 5.4 | 5.5 | 5.6 | 5.9 | 5.8 | 6.2 | 6.2 | 5.5 | 5.2 | 5.6 |

Figure 13 provides a breakdown of absence by short-term and long-term percentage rates between the period June 2014 and May 2015.

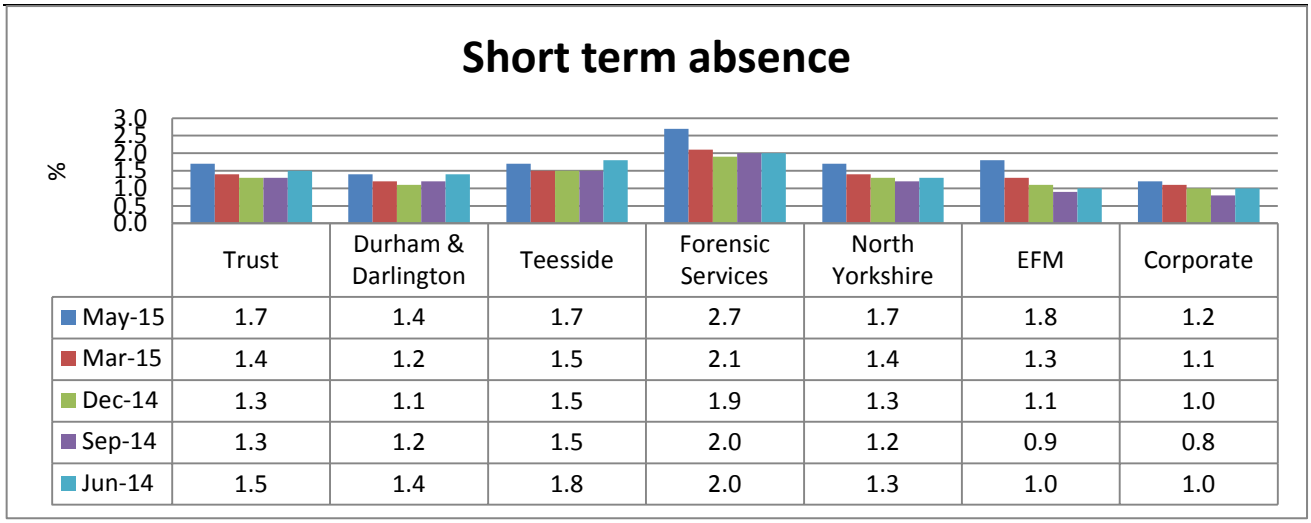
**Figure 13 Short Term and Long Term Sickness Absence Rates**




| | May-15 | Mar-15 | Dec-14 | Sep-14 | Jun-14 |
|---|---|---|---|---|---|
| short term | 1.7% | 1.4% | 1.3% | 1.5% | 1.5% |
| long term | 2.9% | 3.7% | 3.7% | 4.7% | 3.1% |

Figures 14 and 15 provide a breakdown of absence by short-term and long-term percentage rates respectively by locality from June 2014 to May 2015.

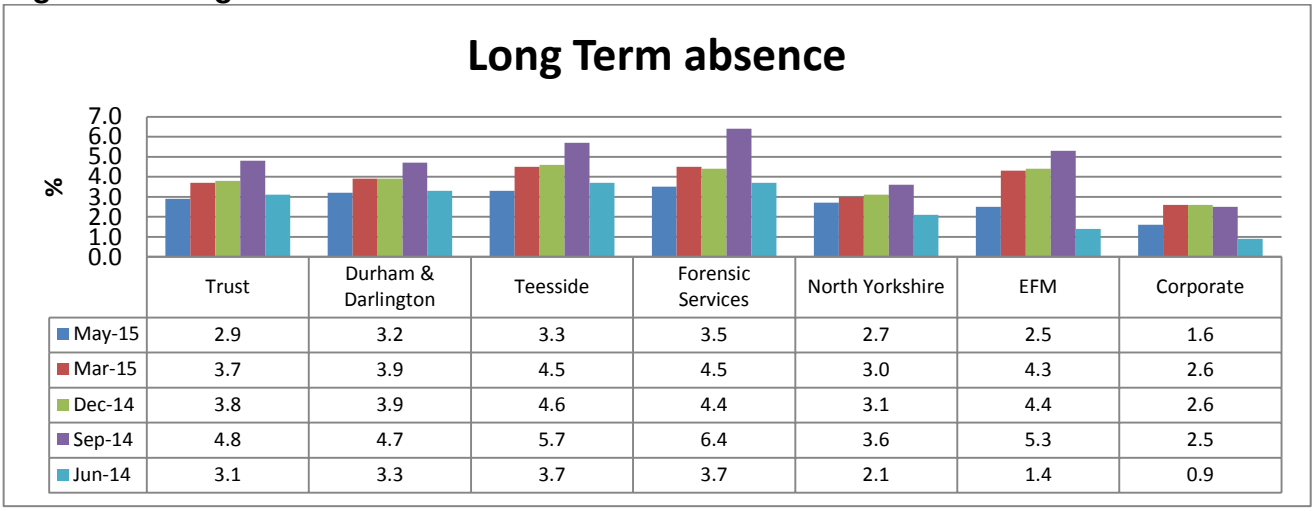
**Figure 14 Short Term Sickness Absence – Trust and Directorate Level**




| | Trust | Durham & Darlington | Teesside | Forensic Services | North Yorkshire | EFM | Corporate |
|---|---|---|---|---|---|---|---|
| May-15 | 1.7 | 1.4 | 1.7 | 2.7 | 1.7 | 1.8 | 1.2 |
| Mar-15 | 1.4 | 1.2 | 1.5 | 2.1 | 1.4 | 1.3 | 1.1 |
| Dec-14 | 1.3 | 1.1 | 1.5 | 1.9 | 1.3 | 1.1 | 1.0 |
| Sep-14 | 1.3 | 1.2 | 1.5 | 2.0 | 1.2 | 0.9 | 0.8 |
| Jun-14 | 1.5 | 1.4 | 1.8 | 2.0 | 1.3 | 1.0 | 1.0 |

During the period **April 2014 to March 2015** the Trust recorded 101,545 fte days lost to sickness absence. **41% (2,432)** of staff recorded no absence during the reporting period and **11% (682)** of staff recorded 3 or more episodes of absence. The cost of sickness absence during the reporting period equated to £8.5m based on salary costs alone. The level of sickness absence during 2014/15 equated to some 250 registered nurse posts being lost during the year.

**Figure 15 Long Term Sickness Absence – Trust and Directorate Level**




| | Trust | Durham & Darlington | Teesside | Forensic Services | North Yorkshire | EFM | Corporate |
|---|---|---|---|---|---|---|---|
| May-15 | 2.9 | 3.2 | 3.3 | 3.5 | 2.7 | 2.5 | 1.6 |
| Mar-15 | 3.7 | 3.9 | 4.5 | 4.5 | 3.0 | 4.3 | 2.6 |
| Dec-14 | 3.8 | 3.9 | 4.6 | 4.4 | 3.1 | 4.4 | 2.6 |
| Sep-14 | 4.8 | 4.7 | 5.7 | 6.4 | 3.6 | 5.3 | 2.5 |
| Jun-14 | 3.1 | 3.3 | 3.7 | 3.7 | 2.1 | 1.4 | 0.9 |

## 8.0 Employee Relations

### Disciplinary Episodes

There were a total of fifteen concluded disciplinary cases during the last quarter, a decrease on the figure of twenty one reported at the end of the previous quarter. Seven of the concluded cases resulted in a disciplinary hearing, the remaining eight investigations resulted in the following outcomes:-

- 2 investigations resulting in counselling.
- 6 were found to have no case to answer.

At the end of June 2015 there were twenty eight ongoing disciplinary cases, at varying stages of the disciplinary process, representing a slight increase on the figure of twenty seven reported in the previous quarter.

A total of fifty five safeguarding incidents were reported during the last quarter, representing an increase on the figure of forty four during quarter four. Seventeen of the cases involved Trust staff. Of these incidents one progressed to a disciplinary hearing with an outcome of no case to answer. One individual has been dismissed from the Trust on health grounds, but the investigation is continuing and an assessment will be made at the conclusion as to whether it should be referred to the Disclosure and Barring Service. One case involved a police investigation and we have received confirmation from the police that they are not pursuing the matter further. The fourth case is still being investigated.

The case from the previous quarterly workforce report (Q4) proceeded to a disciplinary hearing in April resulting in summary dismissal. The individual has appealed against the sanction. There were two cases outstanding from quarter three: one progressed to a disciplinary hearing and no disciplinary sanction was given but the individual was required to attend the Trust's Values and Behaviours training. The investigation into the second case has just been completed and we are awaiting a decision from the Commissioning Manager as to whether the case will proceed to a disciplinary hearing.

Figure 16 provides a breakdown of all ongoing disciplinary cases by directorate.

**Figure 16 Current Locality Disciplinary Case Numbers**

| Trust | Durham & Darlington | Tees | Forensic Services | North York | EFM | Medic Staff | Corp |
|---|---|---|---|---|---|---|---|
| 28 | 3 | 3 | 9 | 8 | 5 | 0 | 0 |

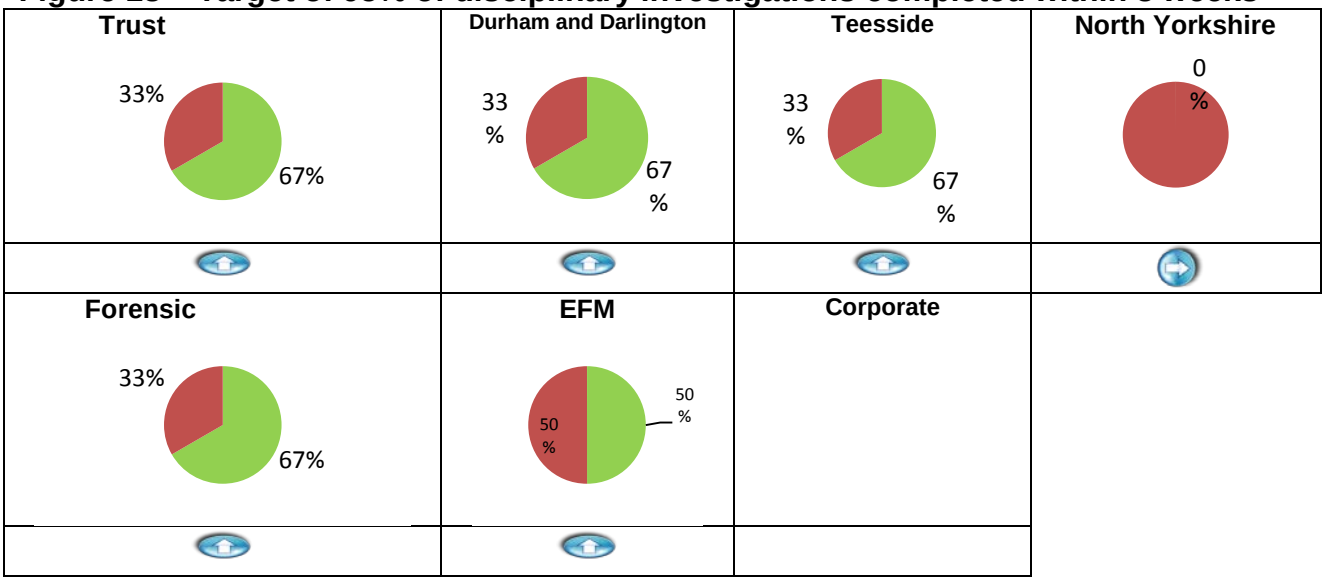
Figure 17 provides the outcomes of the eight disciplinary hearings held during the last quarter. It can be seen that all of the disciplinary hearings held during the last quarter resulted in disciplinary action being taken.

**Figure 17 Disciplinary Hearing Outcomes**

| Summary Dismissal | Alternative to Dismissal | Final Written Warning | Written Warning |
|---|---|---|---|
| 4 | 1 | 1 | 1 |

Figure 18 provides information about performance against the target of completing 95% of disciplinary investigations within 8 weeks, excluding cases delayed due to sickness absence. A total of twenty two disciplinary investigations were concluded during the reporting period. The compliance rate of 67% represents a significant increase on the figure of 18% reported for the previous quarter.

**Figure 18 – Target of 95% of disciplinary investigations completed within 8 weeks**




## Grievances

There were a total of thirty nine concluded grievances within the last twelve months**.** The following table confirms the percentage of grievances concluded within three months of being raised and the average length of time taken to bring to a conclusion.

| | Jun 15 | Mar 15 | Dec 14 | Sep 14 | Jun 14 |
|---|---|---|---|---|---|
| % of grievances concluded within 3 months | 64% | 58% | 51% | 58% | 52% |
| Average length of time in months taken to conclude grievance | 2.6 | 2.9 | 3.1 | 2.9 | 3.75 |

- A total of 10 ongoing grievances were recorded at the end of June 2015 which is an increase on the figure of 8 recorded at the end of March 2015.

Figure 19 shows the percentage of concluded grievances over the last twelve months that were completed within the three months target time. The time taken to conclude grievances has traditionally been less than the time taken to conclude disciplinary matters, and this remains the case.

**Figure 19 Grievances Concluded Within 3 Months**

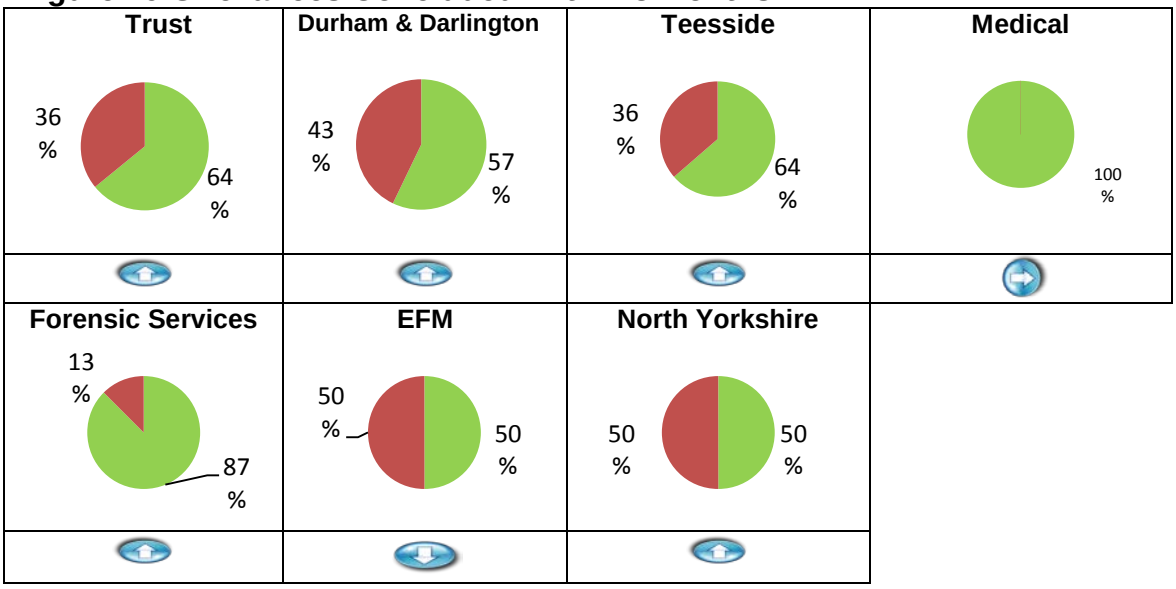
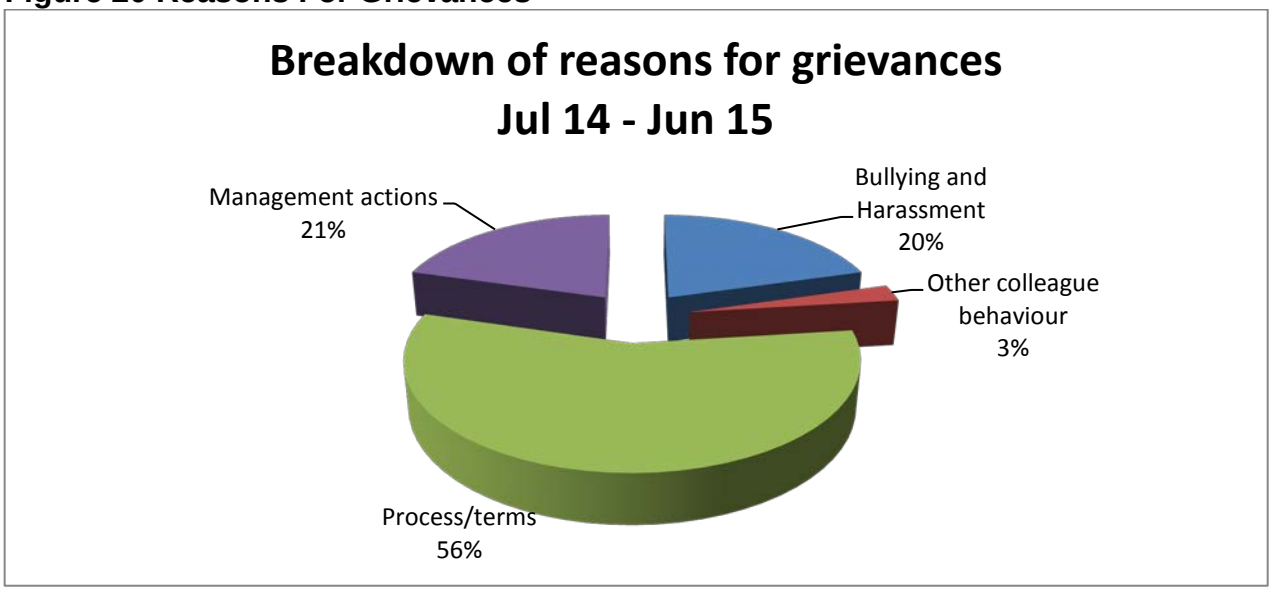



Figure 20 provides a breakdown of the reasons for grievances being lodged. It can be seen that grievances associated with bullying and harassment account for a 20% of all grievances within the Trust. Though the number of such grievances is less than 0.5% of the total Trust workforce it is important to monitor developments in this area and identify any significant trends that may require action on the part of the Trust. 56% of grievances relate to concerns raised relating to process or terms and conditions.

**Figure 20 Reasons For Grievances**



The table below highlights the outcome of grievances lodged during the 12 month reporting period.

**Grievance Outcomes**

| Not upheld | Upheld/resolved | Partially upheld resolved | Mediation | Withdrawn before hearing |
|---|---|---|---|---|
| 12 | 21 | 6 | 1 | 0 |

## Bullying and Harassment

There are four bullying and harassment cases under investigation at the end of June 2015. There have been no bullying and harassment cases that have resulted in a disciplinary process being invoked following the submission of a complaint during the last quarter.

## 9.0 Competence

Figure 21 provides information about the key performance indicator that 95% of staff should receive an annual appraisal resulting in a personal development plan.

**Figure 21 Appraisal and PDP Completion Rates**

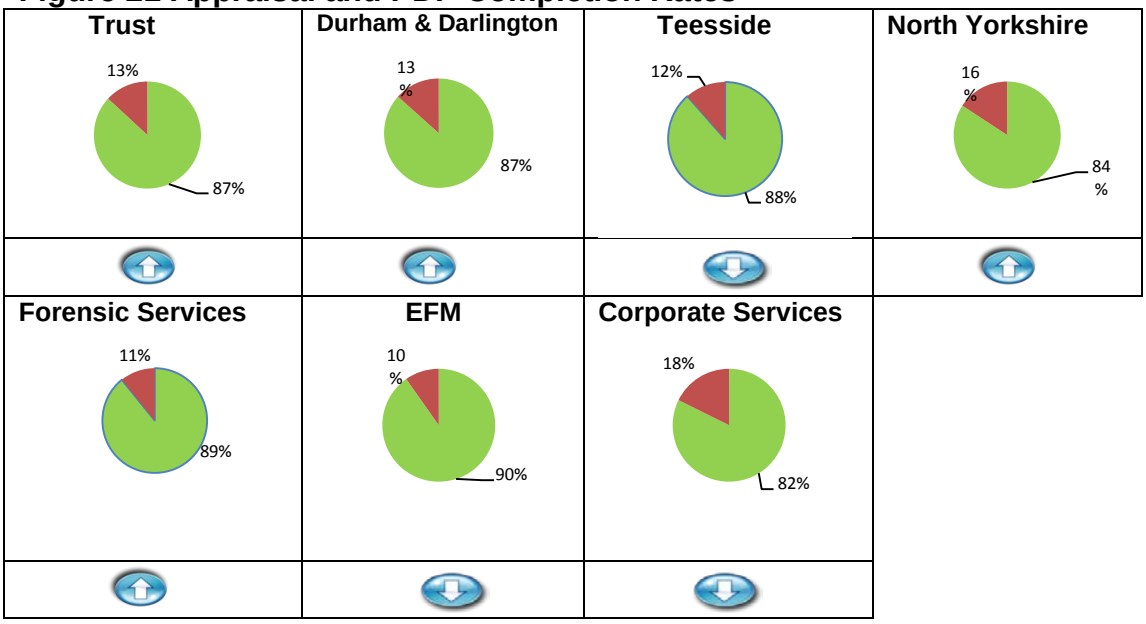
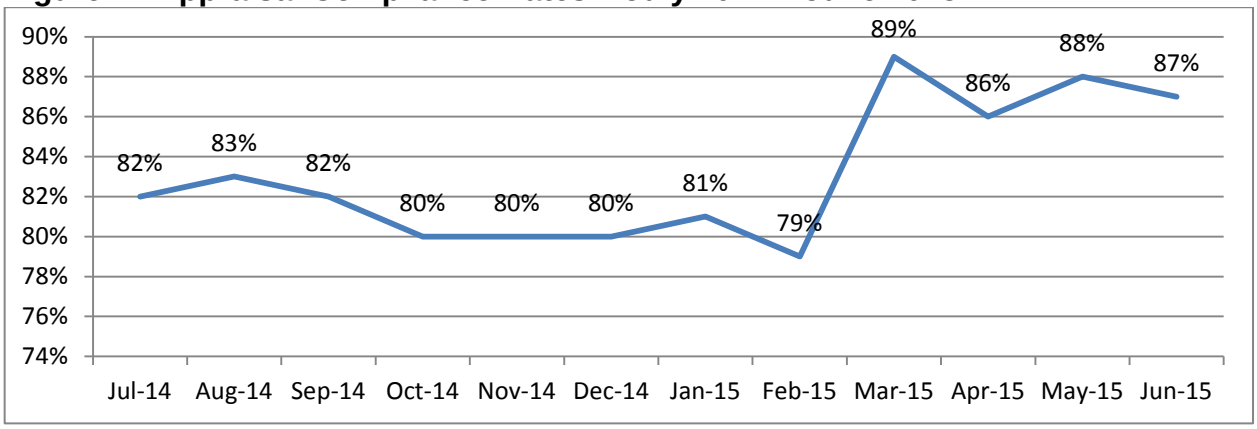



**Figure 22 Appraisal Compliance Rates – July 2014 – June 2015**



Monthly compliance reports are now available on the Integrated Information Centre (IIC) for managers to access and monitor compliance. Managers are able to update appraisal records directly within ESR Manager Self Service. It is envisaged this will help to eliminate the concerns raised regarding the accuracy of the figures reported. To help inform the Board of Directors of efforts being made to increase the number of staff receiving their annual appraisals and personal development plans directorates have provided the following activity updates on pages 13 to 16:-

**Teesside**

MHSOP - the service hold monthly performance meetings which include all band 7 managers and representatives from corporate services including HR. At these each manager reports out on the position relating to all aspects of the HR KPI's for their teams. There is also a centralised monitoring system co-ordinated by the secretary to the Head of Service who on receiving the workforce reports contacts all managers and individual staff contained within the reports to advise of the status and to request updates on any outstanding issues. The information provided is validated against our records and updates relating to any differences are forwarded to the relevant teams within HR.

Adult Mental Health - have performance sessions on a monthly basis where teams report in on key elements including mandatory training and appraisal. A centralised monitoring system co-ordinated by the secretary to the Head of Service who on receipt of the workforce reports contacts all managers and individual staff contained within the reports to advise of the status and to request updates on any outstanding issues. The information provided is validated against our records and updates relating to any differences are forwarded to the relevant teams within HR.

Learning Disability Services - all team managers have a monthly slot on the Tees LD Management meeting. A standard template has been devised for completion which covers a range of KPIs including those pertaining to HR. The meeting includes representatives from the senior management team and corporate colleagues from finance, performance, planning, information and HR. The performance reports are placed on the shared folder and are broken down into individual team/ward areas. The reports are sent to the team managers by the Head of Service admin support where action is needed.

**North Yorkshire**

MHSOP - Progress against the KPIs are monitored via Head of Service monthly 'management and performance meeting and discussed by exception at monthly LMGB meetings with the Director. The Operational Director holds a Contract and Performance monitoring meeting with each speciality each quarter. Locality Managers also monitor compliance within their monthly meetings with their team managers. Action is taken as necessary each month to validate the reports and plan any remedial actions that maybe necessary.

Adult Mental Health Services - Progress against the KPIs are monitored via Head of Service monthly 'management and performance meeting and discussed by exception at monthly LMGB meetings with the Director. The Operational Director holds a Contract and Performance monitoring meeting with each speciality each quarter. Locality Managers also monitor compliance within their monthly meetings with their team managers. Action is taken as necessary each month to validate the reports and plan any remedial actions that maybe necessary.

CYPS services continue to make progress towards targets and monthly monitoring remains in place with Head of service. Appraisals and training is booked in advance as far as places are available. Visual measures have also been implemented to enable managers to proactively address with staff.

Learning Disability Services regularly monitor and evaluate progress made against KPIs and reported through a monthly Business Meeting. The locality performance information is discussed and shared at team meetings/the Senior Clinical Forum meetings on a monthly basis. A visual control board pilot within the Harrogate area for statutory and mandatory training and appraisal is operational.

**Durham and Darlington**

Adult Mental Health Services - compliance is monitored and managed on a monthly basis via management performance meetings, and during individual performance meetings with each ward and team manager. A representative from HR is in attendance at meetings to provide advice and support the processes. All managers with staff showing as non-compliant are asked to provide an update to the Head of Service. Validation of reports occurs on a regular basis and differences are reported to HR.

MHSOP services – monthly performance meetings are in operation involving locality managers, professional leads and representatives from corporate services. The service has introduced fortnightly meetings with ward and team managers. The service is also in the process of introducing fortnightly meetings with ward and team managers to review progress against a range of key performance indicators. The service have also identified internal challenges linked to the key performance indicators such as to achieve compliance against Information Governance training earlier than the required date.

Learning Disability services all HR KPI's are reviewed by the Community Service Manager and Modern Matron through the monthly management meetings where Team Managers are asked to give an update on their team performance against targets.

Effective sickness management of staff within the Integrated Teams has been challenging however there is now an agreement in place for the Community Service Manager and HR Officer to attend the ILDT Managers meetings to support and monitor the sickness management process.

Monitoring of appraisals and mandatory training continues to present some challenges in terms of data reliability necessitating lengthy checking/review each month. However, it is anticipated that this will improve with introduction of ESiS/ESR.

**Forensic Services**

Following an RPIW event the Forensic Service has a system for performance reporting that monitors performance at a ward and team level, with reports being fed through to Modern Matrons and Heads of Service. Action plans are developed for areas of performance that fall below expected levels. This informs the monthly Performance Improvement Discussions with EMT directors.

The service holds monthly performance clinics. The Modern Matrons and Ward Managers attend a monthly meeting, where they report by exception on a range of performance

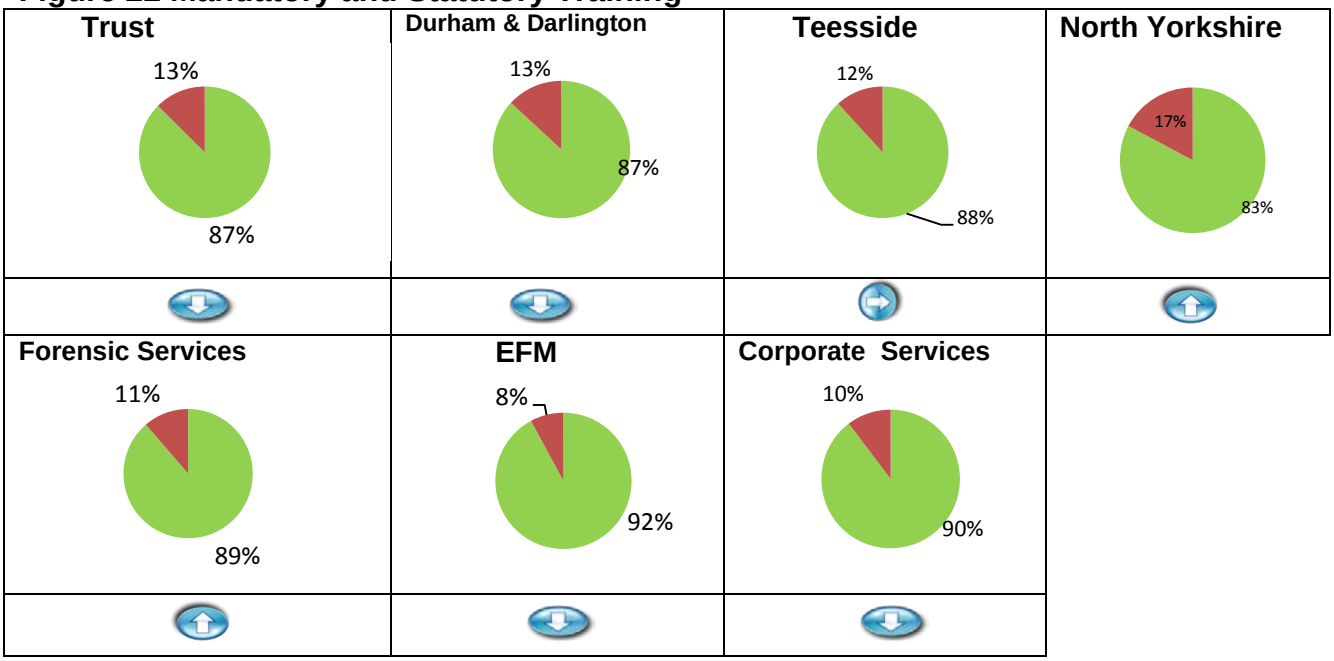
indicators. A performance report out template is completed in advance and in attendance are the Head of Service and representatives from Corporate Services. This places much more focus and responsibility on individual ward and team managers and also corporate services to seek further clarification and challenge specific areas of performance deficits.

There are ongoing discussions with the Police and the Trust Security Officer regarding court proceedings following incidents of Violence and Aggression. The perceived lack of support for initiating criminal proceedings has an impact on staff morale and does not help patients to recognise the consequences of violence towards staff. The Locality LCC reviews workforce indicators with a particular focus on sickness absence and actions to help reduce absence and support staff. The service is currently developing its local response to the Staff Survey, with a focus on the current priorities identified through the Creating Compassionate Care group.

**Mandatory and Statutory Training**

Figure 22 provides information about the percentage of staff undertaking core mandatory and statutory training at the end of June 2015 compared to the Trust target rate of 95%.

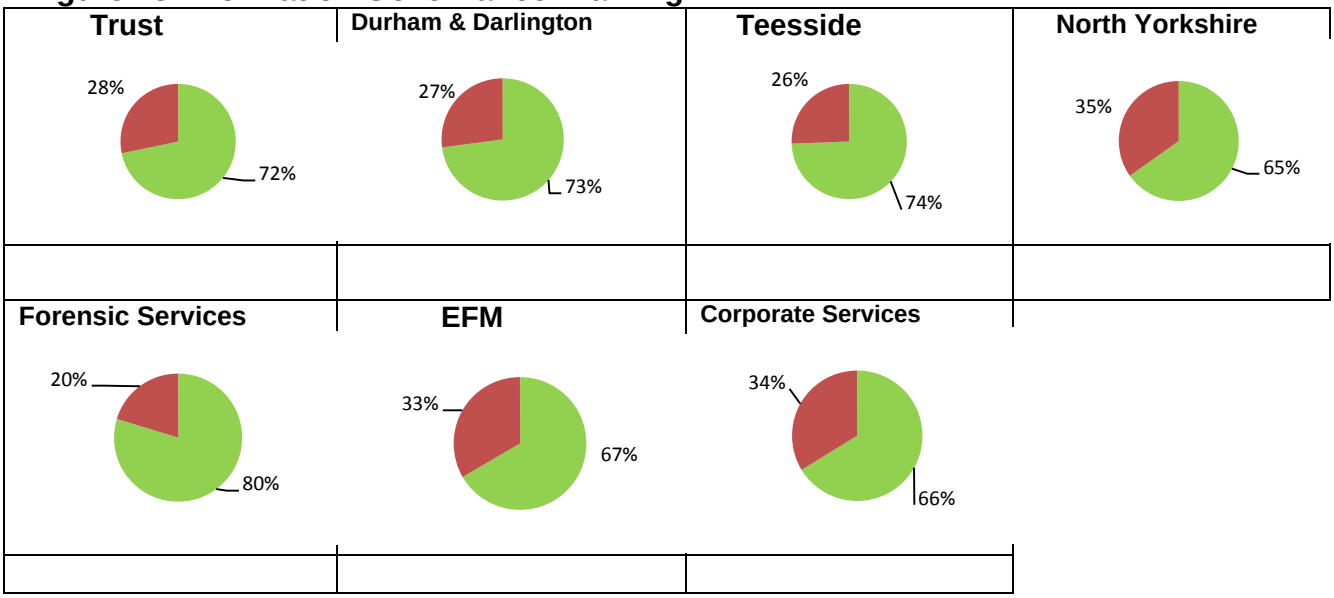
**Figure 22 Mandatory and Statutory Training**




An improvement event was undertaken reviewing the Trust approach to Corporate Induction. One of the outcomes of the event was to reduce the length of time new staff were required to attend induction from 3 days to 1 day. The improvement event reviewed the content of Corporate Induction and as a result the decision was reached to remove the core mandatory training requirements from the event. It was decided that new staff would be required to complete their core mandatory training requirements within 8 weeks of commencing in post. Monitoring of compliance against this target has been undertaken during the report out meetings. Concerns have been raised that the compliance figures are around about the 50% rate. A number of actions have been identified to hopefully remedy the compliance rates over the coming months. It is believed that the compliance rate will be impacting on the overall Trust compliance rate reported above.

Figure 23 shows the compliance rate for Information Governance training as at the end of June 2015 against a target of 95%. Information Governance compliance is based on all staff turning red on 1st April 2015. 72% of staff completed the training within the first quarter of the reporting period.

**Figure 23 Information Governance Training**




## Induction

The 85% corporate induction compliance rate recorded for the last quarter in Figure 24 was a decrease on the figure of 91% reported at end of March 2015 and was below target. This was due to 25 members of staff failing to complete corporate induction within 2 months of commencement of employment during the reporting quarter. The compliance figure excludes bank workers whose compliance rate was 100%.

**Figure 24 Corporate Induction – 100%**

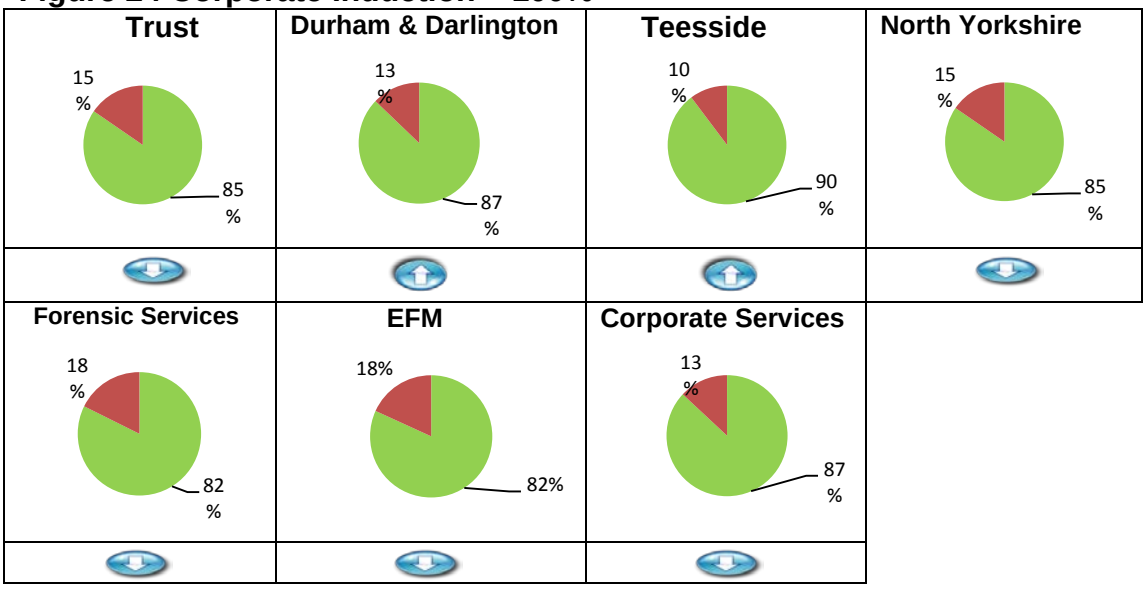
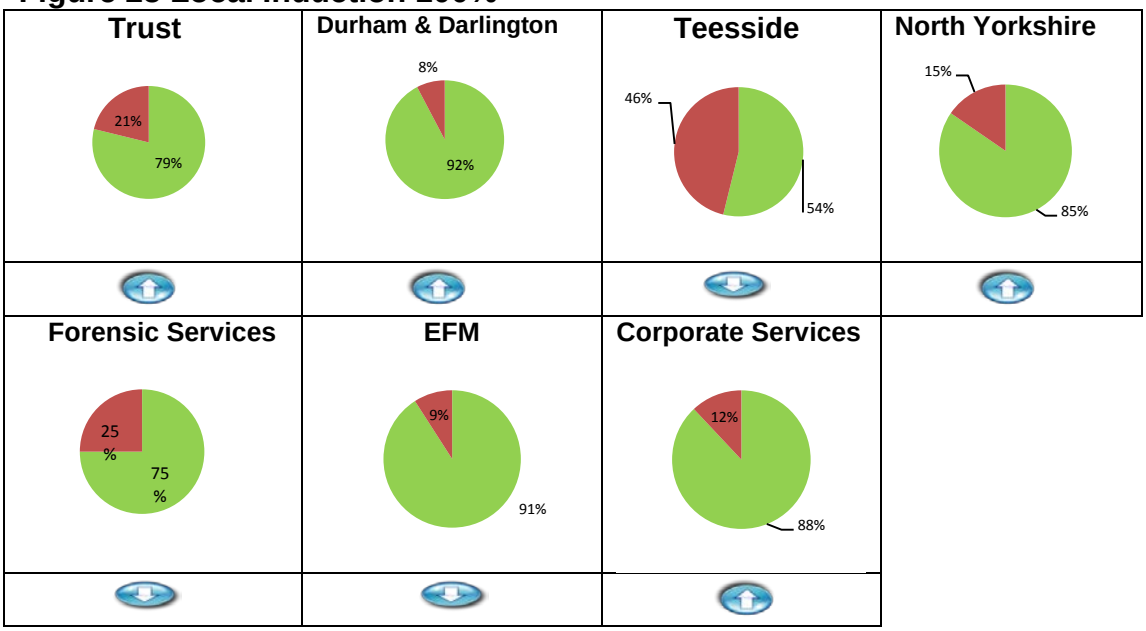


Figure 25 concerns the local induction compliance rate which increased from 74% to 79% in the last quarter. A monthly report is sent out to Heads of Services highlighting those staff requiring local induction, along with a reminder in the middle of the month to confirm outstanding returns. Services are monitoring local induction compliance on a monthly basis through management meetings.

- The 21% non-compliance figure equates to 36 out of 170 staff failing to confirm completion of local induction within the 2 month timescale.
- The compliance figure excludes bank workers. The compliance rate for bank workers completing local induction is 100%

**Figure 25 Local Induction 100%**




## 10.0 Recruitment

- The key performance indicators below provide information about the time taken to recruit to vacancies.
- Percentage of band 1 – 5 vacancies recruited to within 13 weeks of advert being placed against a target of 75%.
- Percentage of band 6 – 9 vacancies recruit to within 15 weeks of advert being placed against a target of 75%
- Figures 26 and 27 show the percentage of staff recruited during the reporting period April to June 2015 compared to the performance indicators identified above.

There were 102 candidates recruited during the reporting period which is a decrease on the previous quarter of 122.

There has been a decrease in the compliance against the target recruitment time for bands 1 – 5 from 63% to 52%. 88% of successful candidates were external applicants which is the same as the figure during the previous quarter. The number of external candidates may have an impact on the length of time taken to recruit due to notice periods required to leave current posts.

- A total of 2 newly qualified staff nurses commenced employment during the reporting period.

The average length of time taken to recruit to bands 1 – 5 remained at 13 weeks for the reporting quarter.

**Figure 26 Bands 1- 5 Recruitment Within 13 weeks**

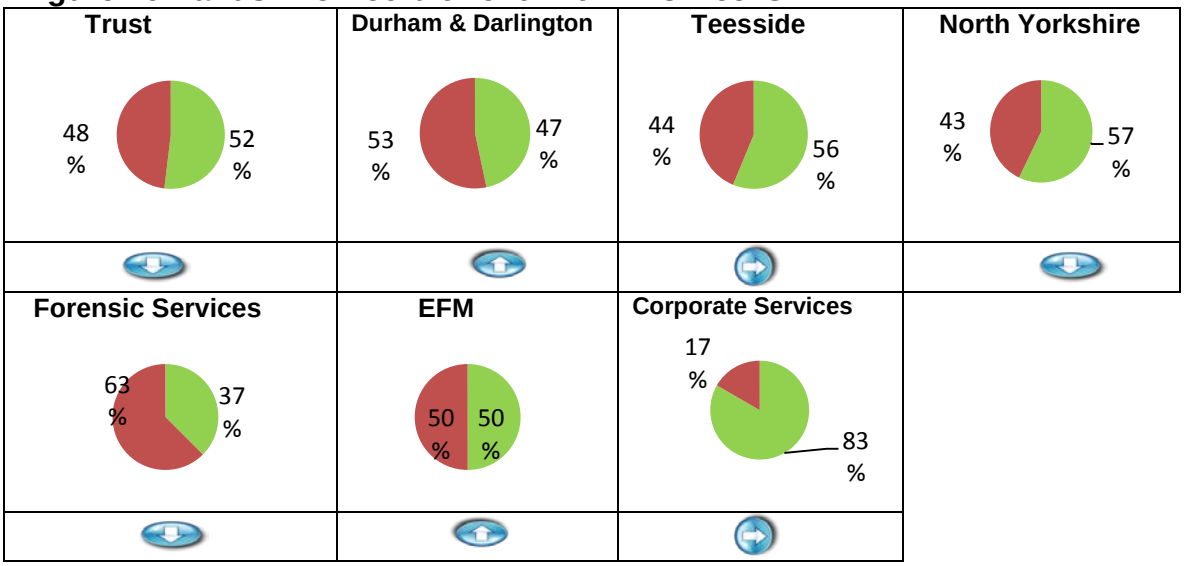
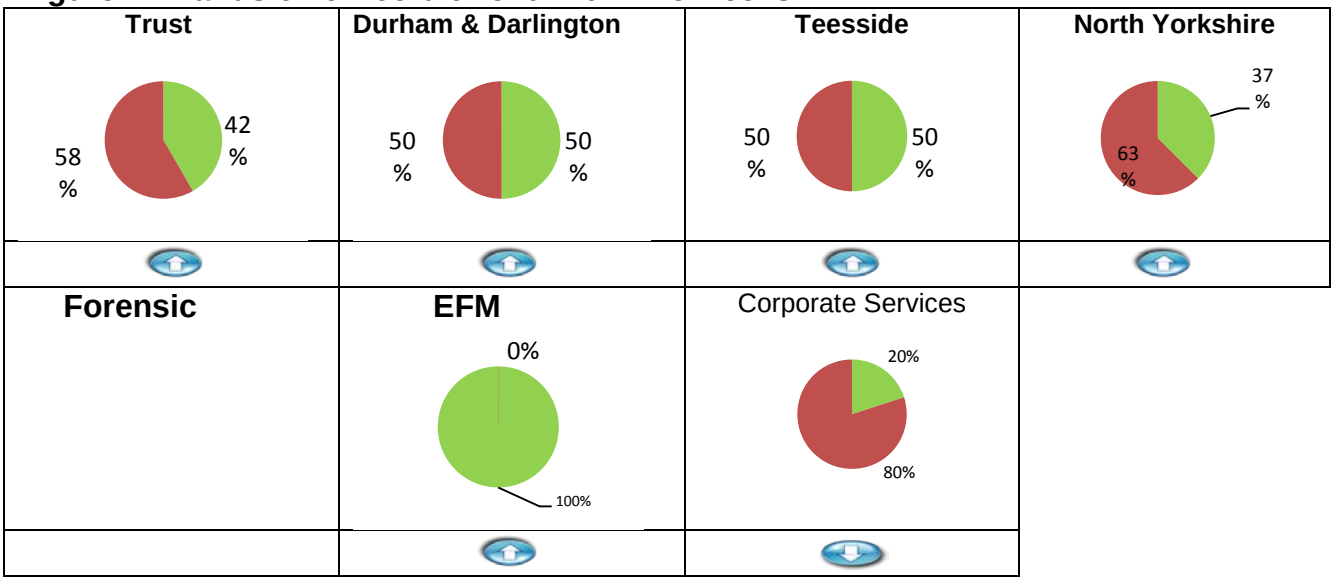



Figure 27 concerns the average length of time taken to recruit to bands 6 and above has reduced to 15 weeks from 16 weeks during the last quarter. 88% of the successful candidates for band 6 and above were external applicants. This is reduction on the figure of 91% reported in the previous quarter.

**Figure 27 Bands 6 - 9 Recruitment Within 15 weeks**




Analysis of recruitment episodes undertaken during the last quarter highlights the following:-

- average length of time taken for short-listing reduced to **4 days from 5 days.** The longest time taken to return short-listing was 79 days, this figure has been excluded from the calculation.
- **10% of** shortlisting was returned within **2 days** which is a significant decrease on the figure of **49%** reported in the previous quarter**.**

- Average length of time taken for references to be received has increased from 16 days to **27 days.**
- **46%** of references were received within **10 days** which is an increase on the figure of 41% reported in the last quarter**.**
- Average length of time taken for Occupational Health clearance to be received has reduced to **7 days** from 10 days.
- **87%** of Occupational Health clearances were received within 10 days representing an increase on the figure of 72% reported during the last quarter.
- Average length of time taken for DBS clearance to be received reduced to **26 days** from 28 days.
- **51%** of DBS clearances were received within **21 days** representing an increase on the figure of 43% reported during the last quarter**.**
- The average length of time taken for pre-employment screening to be completed has increased to **39 days** from **37 days.**
- **31%** of pre-employment screening was completed within 28 days representing a decrease on the figure of 43% reported during the last quarter.

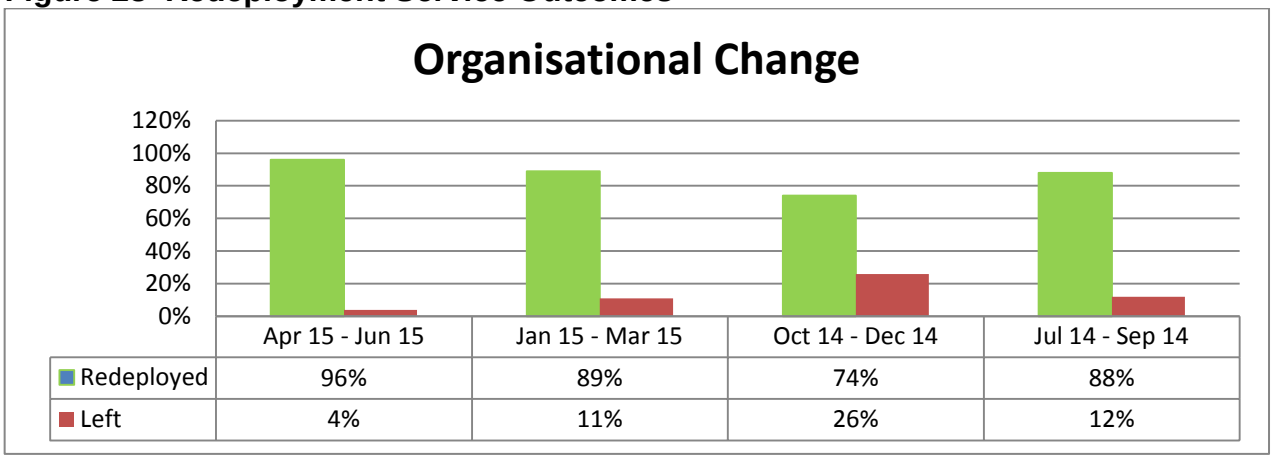
## 11.0 Redeployment Process

The redeployment process is the mechanism adopted within the Trust for searching for suitable alternative employment opportunities for staff finding themselves either displaced or at risk of being displaced from their post as a result of either Organisational Change or on due to medical incapacity.

The table below records the number of staff managed within the redeployment process since July 2014, who have either been successfully redeployed or have left the organisation. Figure 28 highlights the percentage of staff redeployed (green) compared to those leaving the organisation (red).

| | Apr 15 – Jun 15 | Jan 15 – Mar 15 | Oct 14 – Dec 14 | Jul 14 – Sep 14 |
|---|---|---|---|---|
| Number of staff managed within process | 49 | 52 | 34 | 42 |

**Figure 28 Redeployment Service Outcomes**

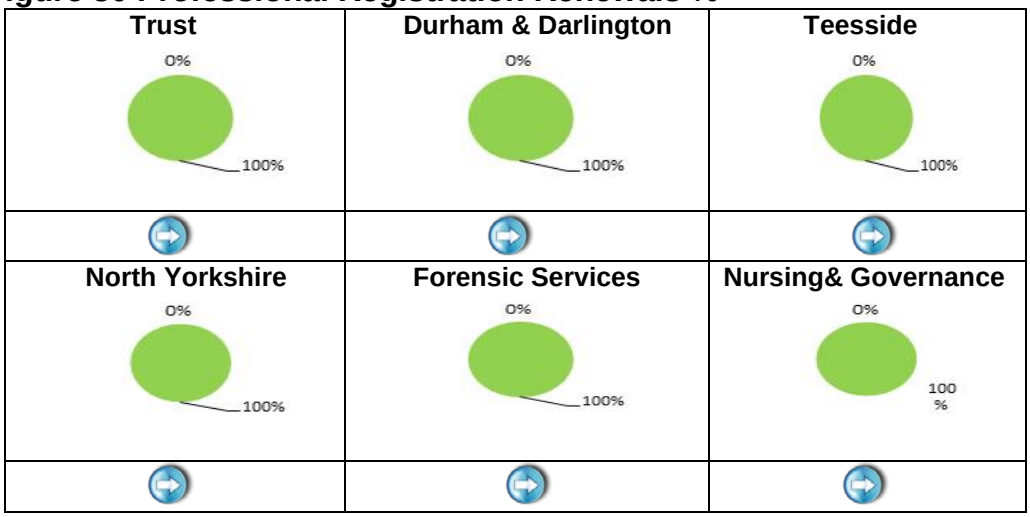


## 12.0 Professional Registration

The Trust target is that 100% of professional registered staff, required to have professional registration, do not allow their professional registration to lapse. Figure 30 below provides a breakdown of the position in respect of those staff whose registration was due to be renewed during the period April 2015 and June 2015.

A total of 426 staff were due to update their professional registration during the reporting period. All members of staff renewed their professional registration during the reporting period. A monthly report has been introduced to alert line managers when a member of staff is due to renew their professional registration and a policy of suspending those staff whose registration lapses, on zero pay, is in place. Where the registration is still showing as not updated the team liaise directly with the employee and the line manager to alert them. This intervention has drastically reduced the number of staff that failed to update their registration.

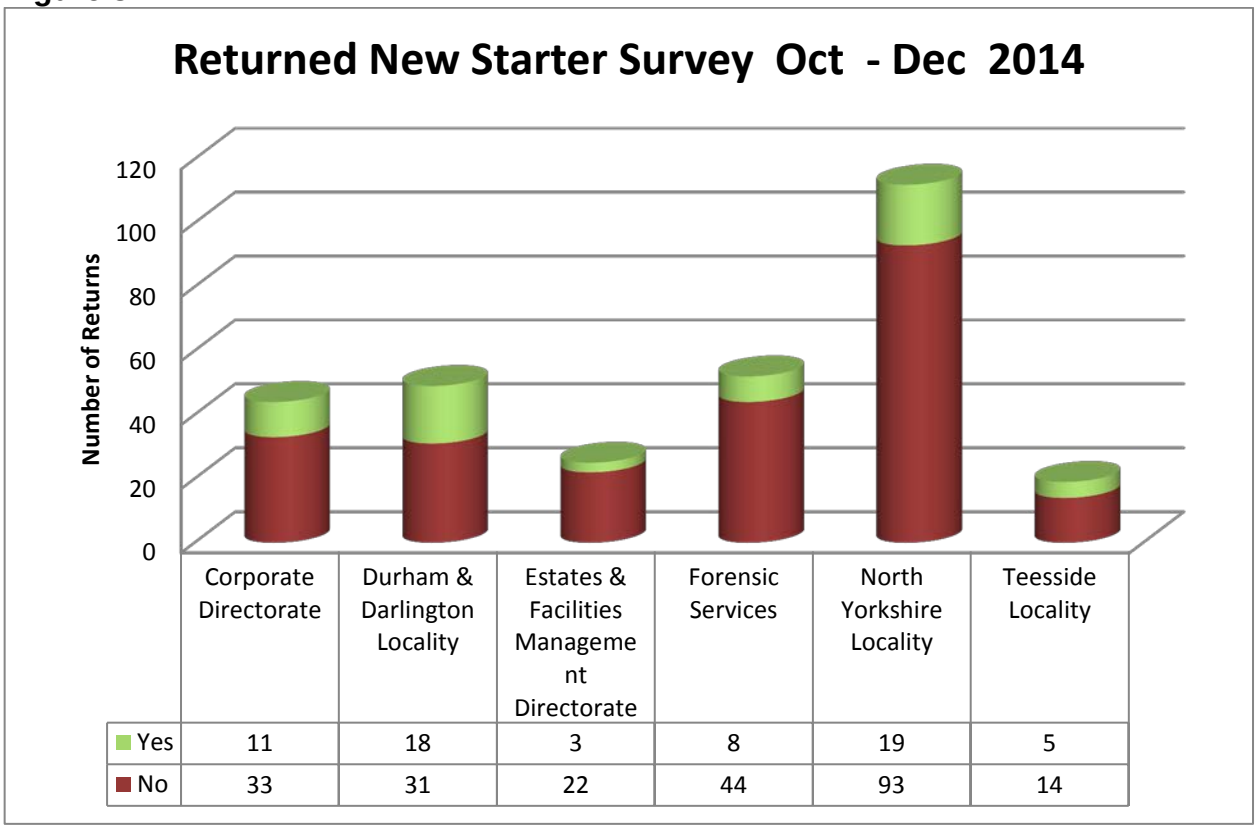
**Figure 30 Professional Registration Renewals %**




## 13.0 New Staff Survey

The Trust introduced a survey of new staff after they have been in post for six months. The survey was introduced in October 2013. The Trust was keen to capture the views of new staff to learn how to improve as an employer and as a provider of service. The graph at figure 31 highlights the return rate of questionnaires by Locality. The graph includes questionnaires sent to staff commencing employment between October and December 2014.

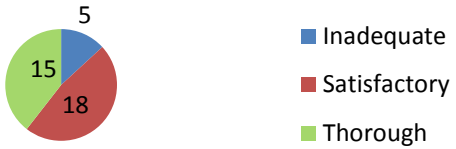
**Figure 31**

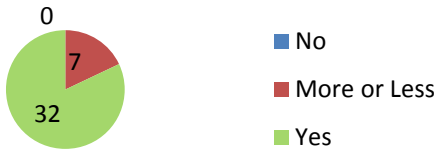


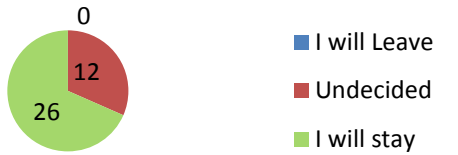
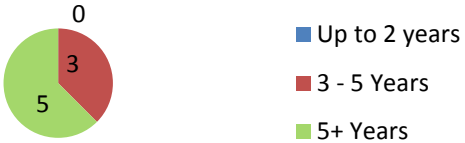

The table below highlights the return rate by month by locality over the last six months. It should be recognised that the number of new staff commencing employment each month can be as small as 1 or 2 which may also influence the return rate.

| | Jul 14 | Aug 14 | Sep 14 | Oct 14 | Nov 14 | Dec 14 | Jul – Dec |
|---|---|---|---|---|---|---|---|
| **Trust** | 19% | 39% | 9% | 24% | 20% | 29% | 21% |
| **Durham and Darlington** | 40% | 100% | 9% | 43% | 30% | 33% | 37% |
| **EFM** | 17% | 0% | 0% | 0% | 0% | 40% | 12% |
| **Forensic Services** | 31% | 33% | 0% | 9% | 11% | 33% | 15% |
| **North Yorkshire** | 11% | 25% | 20% | 23% | 8% | 20% | 17% |
| **Teesside** | 25% | 0% | 14% | 0% | 50% | 100% | 26% |
| **Corporate** | 33% | 43% | 7% | 37% | 33% | 0% | 25% |

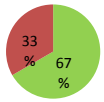
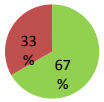
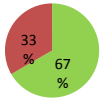
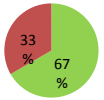
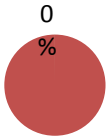
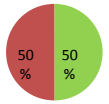
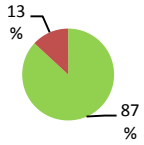
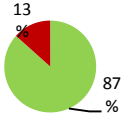
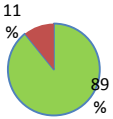
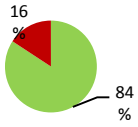
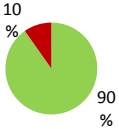
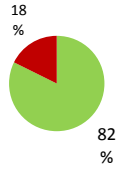
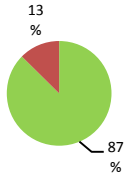
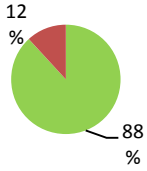
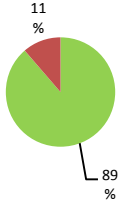
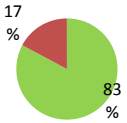
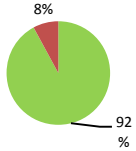
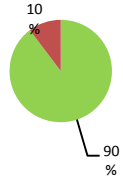
The following graphs highlight the responses received for those staff commencing employment between October 2014 – December 2014.

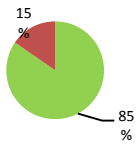
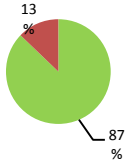
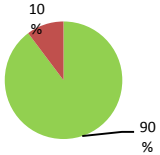
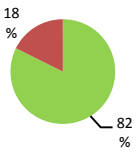
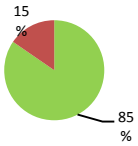
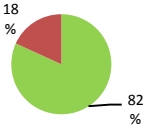
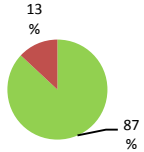
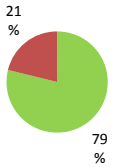
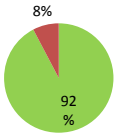
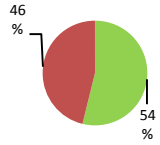
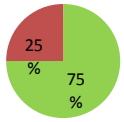
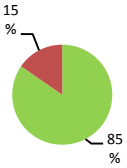
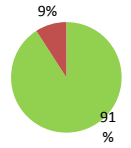
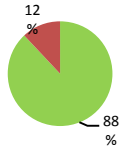
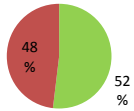
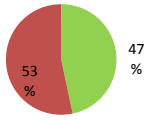
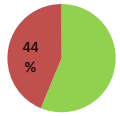
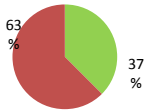
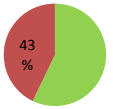
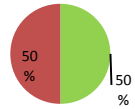
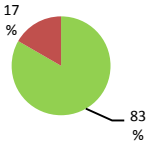
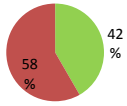
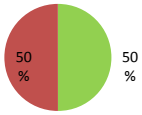
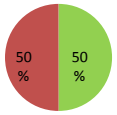
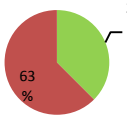
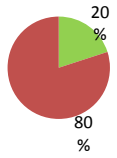
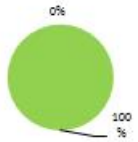
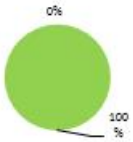
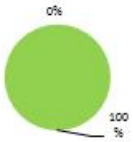
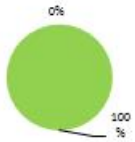
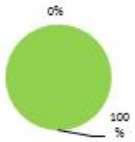
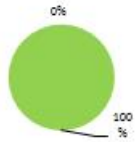
| | | | | | |
|---|---|---|---|---|---|
| Q1 | Before the first day of your work in the Trust were you given clear instructions on where to go and who to report to? |  | Q2 | Were those instructions accurate? |  |
| Q3 | Did the Manager of the service personally meet you on your first day or a different member of staff? |  | Q4 | Were you made to feel welcome by the person who met you? |  |
| Q5 | Were you made to feel welcome by other members of staff in the service? |  | Q6 | Did your Manager spend time reviewing expectations and work requirements? |  |
| Q7 | Did your Manager complete the Local Induction Part1/orientation on your first day? |  | Q8 | Were you assigned to a member of staff who was responsible for your learning? |  |
| Q9 | What was the training like (for example was adequate time, attention, detail etc shown by the person showing you the work of your new job)? |  | Q10 | Do you feel that the person who trained /inducted you, knew the job well enough? |  |

| | | | | | |
|---|---|---|---|---|---|
| Q11 | Did you complete your local induction within 8 weeks of commencing in post? |  | Q12 | Do you feel as though you now know the job well enough to undertake the job with confidence and meet expectations? |  |
| Q13 | Do you know what the requirements for safety are? |  | Q14 | Do you know what the requirements for quality are? |  |
| Q15 | Do you know what the requirements for patient confidentiality are? |  | Q 16 | Does your Manager know and understand the requirements for your job? |  |
| Q17 | What suggestions do you have for improving the training/induction arrangements for new staff in your service? | To provide more regular supervision and to provide more training opportunities.<br>I felt that the two day corporate induction I attended was a little too intensive for me as someone new to the health service as well as the trust. I personally would have benefitted from an induction that was spread out over several shorter sessions<br>The Trust Induction could give me more notice of need to attend as the short notice period made me have to cancel appointments, which I am uncomfortable with. I suggest that when contract is sent out with workbase details you also include date of trust induction.<br>Induction should happen earlier, possibly first week. Induction was very intense and felt it was rushed. Too much information at one time.<br>I have an administrator role and the previous administrator had left so there was no one to provide a real hand over so training/induction for specific elements of the job proved difficult. Maybe the outgoing administrator could have left some notes about specific duties. This would have proved helpful<br>I received a very high caseload, prior to starting I did not know this would be the case especially for a newly qualified nurse.<br>Could do the induction through e-learning or cut down a lot of the paper. It seemed like a lot of ticking boxes and stuff was out of date. IT training and numeracy and literacy training should also be offered<br>I didn't go to induction but I did the Mandatory core training tests that they asked me to do. No improvements.<br>Two week supernumery for preceptorship not given , would of (sic) been helpful<br>Shadowing a person of the same job role for a few days/week. More robust/structured; perhaps a timetable of things. Only felt comfortable as I had previously worked in the trust, which is perhaps why my induction was not as comprehensive as others<br>When aware of successful application of job, prior to start date, have training booked in already. Eg Medicines management wasn't until January and I started in November so a long wait before could help with medications. MOVA training and basic response could all be booked in ready for start on ward. ID badges should be made and handed out at Trust Induction.<br>TEWV Induction needs to be more interactive. People were losing concentration being sat in the same position watching power point presentations for hours! | | | |

| | | | | | |
|---|---|---|---|---|---|
| Q18 | Would you recommend the service in which you work to anyone else to work in? |  | Q19 | How likely is it that you will decide to continue working in the Trust? |  |
| Q20 | Have the Trust Values and associated Behaviours been explained to you? |  | Q21 | Are you comfy with those Values and Behaviours? |  |
| Q21 | Do you have any suggestions for improvements that might reduce waste/and or improve quality within either the service you are employed within or, more broadly, within the Trust? | My service:- possibly could benefit from some dedicated training hours included in the first 4 weeks to allow for e-learning. Trustwide:- Improve the quality outcome measures returned by placing them in PARIS as a drop down box that can be accessed centrally for the data, this would save Care Co-ordinators having to sign paper sheets e.g. care plans given, and admin having to email compliance data.<br>To encourage the use of email to forward documents rather than documents rather than paper copies being sent in the post<br>Too much paper work unnecessary (sic) that makes both our jobs much more difficult, waste of time and far too much paper work for both staff and patients. Time could be much better spent actually with the patients rather than filling out forms.<br>Update of software/hardware on the computers (including RAS) - can take 30 minutes for a computer to log on sometimes - waste of time. RAS is very clow when only connected to 3G: doubles the working time. Encouragement of staff taking their lunch times together (at least once a week) to improve working relationships. Seems to be the norm that people generally work through their lunch time due to high workload- think this will improve relationships/quality of working environment.<br>As above, improve when training is booked, no reason why cannot be booked before start date so that it is already booked in when start on ward. | | | |
| Q22 | How long would you envisage remaining in the employment of the Trust? |  | Q23 | Is your contract permanent or fixed term? |  |

## KEY PERFORMANCE INDICATOR SUMMARY

| | Key Performance indicators | Target | Trust | Durham & Darlington | Teesside | Forensic | North York | EFM | Corp |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Labour Turnover rate | 8% - 12% | 10.0% | 9.53% | 9.31% | 8.7% | 11.4% | 8.3% | 12.5% |
| 2 | Sickness Absence FYTD | 4.5 % | 4.6% | 4.6% | 4.9% | 6.3% | 4.5% | 3.9% | 2.4% |
| 3 | % of investigations concluded within 8 weeks | 95% |  |  |  |  |  |  | |
| 4 | % of staff receiving an annual appraisal | 95% |  |  |  |  |  |  |  |
| 5 | % of staff compliant with mandatory and statutory training | 95% |  |  |  |  |  |  |  |

| | Key Performance indicators | Target | Trust | Durham & Darlington | Teesside | Forensic | North York | EFM | Corp |
|---|---|---|---|---|---|---|---|---|---|
| 6 | % of new starters attending corporate induction within 3 months of commencing employment | 100% |  |  |  |  |  |  |  |
| 7 | % of new starters confirmation of local induction checklist completed within 3 months of commencing employment | 100% |  |  |  |  |  |  |  |
| 8 | % of band 1 -5 recruited within 13 weeks | 75% |  |  |  |  |  |  |  |
| 9 | % of band 6 – 9 recruited within 15 weeks | 75% |  |  |  | |  |  |  |
| 10 | % of professional registered staff with a current professional registration against a target of 100% | 100% |  |  |  |  |  | |  |

# Medical Workforce Report (2015 Quarter 1) Appendix 2

## MEDICAL DIRECTORATE

This report provides information about the medical workforce during the first quarter, April to June 2015.

**The report will be divided into the following sections:**

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

# Section 1: Medical Staffing Profile

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

| Table 1 | D&D | Tees | N Yorks | Forensic | Overall Total |
|---|---|---|---|---|---|
| **Permanent** | 100 | 86 | 69 | 34 | 289 |
| **Trust Locums** | 3 | 7 | 9 | | 19 |
| **Agency Locums** | 3 | 2 | 4 | 2 | 11 |
| **Flex Retirement** | 5 | 1 | 3 | | 9 |
| **Career Break** | 2 | 1 | | 1 | 4 |
| **Honorary** | 2 | | 1 | 1 | 4 |
| **Total** | 115 | 97 | 86 | 38 | **336** |

Table 1 shows that 34% of our permanent workforce is in the D&D locality. North Yorkshire has the most Trust locums (9) and agency locums (4).

The table identifies that the permanent workforce make up 86% of the medical workforce. This compares comparably with the percentage in 2013.

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

## Consultant Psychiatrists

| Table 2 | AMH | CYPS | MHSOP | LD | FMH | FLD | Total |
|---|---|---|---|---|---|---|---|
| **Permanent** | 53 | 31 | 25 | 11 | 12 | 8 | 140 |
| **Trust Locums** | 1 | | 2 | | | | 3 |
| **Agency Locums** | 3 | | 1 | | 1 | 1 | 6 |
| **Flex Retirement** | 4 | 4 | | 1 | | | 9 |
| **Vacant not cov'd** | 2 | 2 | 1 | | | | 5 |
| **Career Break** | 2 | | | | | 1 | 3 |
| **Honorary** | 2 | 1 | | | 1 | | 4 |
| **Total** | 67 | 38 | 30 | 12 | 14 | 10 | **171** |

Table 2 shows the number of consultants currently working within the Trust defined by specialty. The overall number of permanent staff has increased, however, the number of locums (including agency locums) has significantly decreased from the last quarter (16 locums last quarter down to 9). Please note that out of the 6 agency doctors, 3 are covering vacant posts, one is covering a career break and 2 are covering maternity leave. Of interest is that one of the agency locums from last quarter has now joined on a trust locum contract.

The consultant workforce in AMH is of concern given 21% of its workforce is not permanent and may pose a risk in the future. Figures from 2014 show the same ratio of permanent consultants and locum consultants.

## SAS Doctors

| Table 3 | AMH | CYPS | MHSOP | LD | FMH | FLD | Total |
|---|---|---|---|---|---|---|---|
| **Permanent** | 16 | 5 | 11 | 1 | 4 | 3 | 40 |
| **Trust Locums** | 1 | | 2 | | | | 3 |
| **Agency Locums** | | 1 | 2 | | | | 3 |
| **Flex Retirement** | | | | | | | |
| **Vacant not cov'd** | 1 | 2 | | | | 1 | 4 |
| **Career Break** | | | 1 | | | | 1 |
| **Honorary** | | | | | | | |
| **Total** | 17 | 7 | 16 | 1 | 4 | 4 | **51** |

Table 3 shows the number of SAS grade doctors currently working within the Trust defined by specialty. This shows the position is largely unchanged from the last quarter.

## Junior Doctors

| Table 4 | AMH | CYPS | MHSOP | LD | FMH | FLD | Total |
|---|---|---|---|---|---|---|---|
| **Current** | 55 | 9 | 21 | 6 | 6 | 1 | 98 |
| **Vacancies not covered** | 7 | 4 | 4 | 2 | 1 | | 18 |
| **Trust Locums** | 7 | | 4 | | | | 11 |
| **Agency Locums** | | | 1 | | | | 1 |
| **Total number of posts** | 69 | 13 | 30 | 8 | 7 | 1 | **128** |

Table 4 shows all Trust junior doctor training posts. This is unchanged since the last quarter as the junior doctors rotate in February and August. The number of vacancies are those posts that remain unfilled after trust doctor and agency locums have been appointed. For information, Trust doctors are used to fill vacant training posts and are not on a formal training programme. There are currently 30 vacancies that are either filled by locums or that remain empty.

You will note that the Trust has 11 Trust doctor posts compared to 3 in 2013. This is quite unique and is as a consequence of the Trust doctor initiative whereby the Trust advertised opportunities for Trust doctors, mostly equivalent to the level of foundation one or two, to work and receive a tailored development programme. The programme was developed to make the doctor better equipped to be succesful on their application for core training. A paper will be presented to EMT shortly to ask for consideration of further support of this initiative and to widen its scope to work with our neighbouring Trust to share costs.

| Table 5 | AMH | CYPS | MHSOP | LD | FMH | FLD | Total |
|---|---|---|---|---|---|---|---|
| **Foundation Yr 1** | 9 | | 3 | | | | 12 |
| **Foundation Yr 2** | 6 | | 3 | | 1 | | 10 |
| **CT 1-3** | 20 | 4 | 9 | 4 | 3 | | 40 |
| **ST 4-6** | 9 | 5 | 3 | 2 | 2 | 1 | 22 |
| **GP Registrars** | 11 | | 3 | | | | 14 |
| **Total** | 55 | 9 | 21 | 6 | 6 | 1 | **98** |

Table 5 shows the breakdown of junior doctors that are currently in post in the Trust. Of particular concern is the low number of higher trainees (SpR's) in specialties where we struggle to attract sufficient numbers of quality consultant applicants (33% of the 30 vacancies are higher trainee posts). This pattern will unfortunately continue until we are able to fill all of the core training posts in both regions.

On a more positive note, we continue to do all we can to support core trainees in passing their written and clincial papers. We have introduced the independent assessment of clincial skills (IACS), and this is now held twice yearly. A structured day long CASC programme was lauched last year and we continue to encourage opportunitist clincial skills training with trained supervisors.

In December Dr Peter Horn ran the day long CASC programme and 17 doctors attended. 14 of those went on to sit the CASC examination in January 2015 and of the 14, 10 candidates passed the exam giving a 71% pass rate, comparing very favourably with previous groups. There are obviously other contributing factors to these results but the immediate feedback from the event was very positive.

# Section 2: Medical Staffing Monitoring Profile

This section provides analysis of gender, age and ethnicity of the medical staff workforce.

## Consultants by Age & Gender

| | D&D | | Tees | | NY | | Forensic | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Table 1** | Male | Female | Male | Female | Male | Female | Male | Female | **M** | **F** |
| 30 – 34 | 1 | 2 | 2 | 2 | | 1 | 1 | | **4** | **5** |
| 35 – 39 | 4 | 7 | 9 | 3 | 3 | 3 | 3 | 3 | **19** | **16** |
| 40 – 44 | 9 | 4 | 3 | 4 | 6 | 2 | 3 | 3 | **21** | **13** |
| 45 – 49 | 6 | 3 | 4 | 2 | 8 | 5 | 5 | 1 | **23** | **11** |
| 50 – 54 | 6 | 9 | 4 | 2 | 2 | 2 | 2 | | **14** | **13** |
| 55 – 59 | 4 | 2 | 1 | 3 | 2 | | 1 | | **8** | **5** |
| 60 – 64 | 2 | 1 | 2 | | 3 | | | | **7** | **1** |
| 65 – 69 | | | | | | | | | | |
| 70+ | | | | | | | | | | |
| **Total** | **32** | **28** | **25** | **16** | **24** | **13** | **15** | **7** | **96** | **64** |

Table 1 shows the number of male and female consultants categorised by age profile in each locality. The data includes all staff (eg permanent, locum, flexible retiree – except agency locums).

The majority of our consultant workforce is aged between 35 and 49 (64%), however, the modal average has decreased slightly from last quarter (40-44) and is now 35-39 age group. This is most likely due to a number of 44 year olds having birthdays this quarter. The male and female split in Durham and Darlington is still fairly equal which is not replicated in the other localities. Overall, there is a 60/40% male/female split respectively (females rising by 1% from last quarter).

Figures from the GMC are showing an increase in females graduating – in 2011, 53% of those gaining GMC registration were female. In addition, the number of females on the register is expected to exceed the number of males by 2017 (GMC, 2012). This suggests that the male to female ratio may even out in the Trust over the next few years.

## Consultants by Age & Gender in Specialties

| Table 2 | AMH | | CYPS | | MHSOP | | LD | | Forensic MH | | Forensic LD | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | M | F | M | F | M | F | **M** | **F** |
| 30 – 34 | 1 | 2 | | 2 | 1 | 1 | 1 | | 1 | | | | **4** | **5** |
| 35 – 39 | 8 | 6 | 2 | 4 | 3 | 1 | 3 | 2 | 2 | 1 | 1 | 2 | **19** | **16** |
| 40 – 44 | 9 | 5 | 5 | 2 | 3 | 2 | 1 | 1 | 2 | 1 | 1 | 2 | **21** | **13** |
| 45 – 49 | 9 | 3 | 4 | 4 | 4 | 3 | 1 | | 4 | 1 | 1 | | **23** | **11** |
| 50 – 54 | 8 | 1 | 3 | 6 | 1 | 4 | | 2 | 1 | | 1 | | **14** | **14** |
| 55 – 59 | 3 | 2 | 1 | 2 | 2 | 1 | 1 | | | | 1 | | **8** | **5** |
| 60 – 64 | 4 | 1 | 2 | | 1 | | | | | | | | **7** | **1** |
| 65 – 69 | | | | | | | | | | | | | | |
| 70+ | | | | | | | | | | | | | | |
| Total | 42 | 20 | 17 | 20 | 15 | 12 | 7 | 5 | 10 | 3 | 5 | 4 | **96** | **64** |

Table 2 shows the number of male and female consultants in various age brackets defined by specialty. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. Interestingly, Forensic Services has a relatively young workforce with only 3 out of 22 doctors over the age of 50, while the other specialties together make up 31% of the consultant workforce over the age of 50.

In addition, the lack of a female workforce in Adult Mental Health and Forensic Mental Health is quite evident from the data.

## SAS Doctors by Age & Gender

| Table 3 | D&D | | Tees | | NY | | Forensic | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Male | Female | Male | Female | **M** | **F** |
| 30 – 34 | 1 | | | | | | 1 | | **2** | |
| 35 – 39 | 1 | | | | | 2 | 1 | | **2** | **2** |
| 40 – 44 | 1 | 2 | 1 | 2 | | 1 | | 1 | **2** | **6** |
| 45 – 49 | 3 | 3 | | 3 | 1 | 3 | 1 | 1 | **5** | **10** |
| 50 – 54 | 2 | 1 | 1 | 2 | | 1 | 1 | 1 | **4** | **5** |
| 55 – 59 | | 1 | 1 | 1 | | 1 | | | **1** | **3** |
| 60 – 64 | | | | 1 | | | | | | **1** |
| 65 – 69 | | | | | | | | | | |
| 70+ | 1 | | | | | | | | **1** | |
| **Total** | **9** | **7** | **3** | **9** | **1** | **8** | **4** | **3** | **17** | **27** |

Table 3 shows the number of male and female SAS doctors in various age brackets defined by locality. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. In comparison to the consultant workforce, there is a 39/61% split in favour of females, with noticably few males (1) in the North Yorkshire locality (very similar to last quarter). In addition, the average workforce age is slightly higher (45-49), with nearly a third (30%) being over the age of 50. It is also worth noting that our Teesside locality has a high proportion of its workforce in the over 50 category (58%).

### SAS Doctors by Age & Gender in Specialties

| AMH | CYPS | MHSOP | LD | Forensic MH | Forensic LD | Total |
|---|---|---|---|---|---|---|

| Table 4 | M | F | M | F | M | F | M | F | M | F | M | F | **M** | **F** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 30 – 34 | 1 | | | | | | | | 1 | | | | **2** | |
| 35 – 39 | 1 | | | 1 | | 1 | | | 1 | | | | **2** | **2** |
| 40 – 44 | | 3 | | 1 | 2 | 1 | | | | | | 1 | **2** | **6** |
| 45 – 49 | 2 | 4 | | 1 | 2 | 4 | | | | 1 | 1 | | **5** | **10** |
| 50 – 54 | 2 | 2 | | 1 | 1 | 1 | | | | | 1 | | **4** | **5** |
| 55 – 59 | 1 | | | 1 | | 1 | | 1 | | 1 | | | **1** | **3** |
| 60 – 64 | | 1 | | | | | | | | | | | | **1** |
| 65 – 69 | | | | | | | | | | | | | | |
| 70+ | | | | | 1 | | | | | | | | **1** | |
| Total | 7 | 10 | | 5 | 6 | 8 | | 1 | 2 | 2 | 2 | 1 | **17** | **27** |

Table 4 shows the number of male and female SAS doctors in various age brackets defined by specialty. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. It should be noted that male and female numbers are fairly even, except in CYPS where all doctors are female.

## Ethnic Origin

| **Consultants** | **D&D** | | **Tees** | | **NY** | | **Forensic** | | **Total** | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Table 5** | Male | Female | Male | Female | Male | Female | Male | Female | **M** | **F** |
| White British | 12 | 17 | 8 | 12 | 12 | 10 | 8 | 2 | **40** | **41** |
| White Irish | 2 | | | | | | | 1 | **2** | **1** |
| White European | 2 | 1 | 2 | 1 | 3 | | | | **7** | **2** |
| White Polish | | | | | | | 1 | | **1** | |
| White Other | | | 1 | | | | | | **1** | |
| Asian British – Indian | 13 | 5 | 10 | 1 | 4 | 1 | 2 | 4 | **29** | **11** |
| Asian British–Pakistani | | | | | 1 | | 2 | | **3** | |
| Asian British–Bangladesh | | | | | 1 | | | | **1** | |
| Asian British–Other | 1 | | 1 | 1 | | | | | **2** | **1** |
| Black British–African | | 1 | | 1 | 2 | | | | **2** | **2** |
| Black British - Nigerian | 1 | | | | | | | | **1** | |
| Black British–Other | 1 | | 1 | | | | 1 | | **3** | |
| Mix White/Black–African | 1 | | | | | | | | **1** | |
| Mixed – Other | | | 1 | | | | 1 | | **2** | |
| Chinese | | 1 | | | | | | | | **1** |
| Other | 1 | 1 | | 1 | 1 | 1 | | | **2** | **3** |
| Not Stated | | | | | | 1 | | | | **1** |

Table 5 shows the number of male and female consultants in ethnic origin categories defined by locality. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. The table shows that just over half of the consultant workforce are 'White British' (81 White British and 79 non-White British).

When considering BAME consultants, 95 are from the EU while 65 are from Asia, Africa or elsewhere (59/41% respectively). Interestingly, the male/female split between the EU area and BAME areas is

quite distinct – 54% of the EU workforce are male and 46% are female; in BAME areas, 73% of the workforce are male compared to 27% female. North Yorkshire have twice as many EU consultants as BAME.

**SAS Doctors**

**Table 6**

| | D&D | | Tees | | NY | | Forensic | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Male | Female | Male | Female | **M** | **F** |
| White British | 4 | 4 | | 3 | | 4 | 1 | | **5** | **11** |
| White European | | | | | | 1 | | | | **1** |
| White Other | 1 | | | 2 | | | | 2 | **1** | **4** |
| Asian British–Indian | | 2 | 3 | 3 | 1 | | | | **4** | **5** |
| Asian British–Pakistani | | | | | | 1 | 1 | | **1** | **1** |
| Asian British- Banglaesh | 1 | | | | | | | | **1** | |
| Asian British–Other | | | | | | 1 | | 1 | | **2** |
| Black British–African | | 1 | | | | | 1 | | **1** | **1** |
| Black British-Nigerian | 1 | | | | | | | | **1** | |
| Black British | 1 | | | | | | | | **1** | |
| Mix White/Black African | | | | | | | 1 | | **1** | |
| Vietnamese | | | | 1 | | | | | | **1** |
| Other | 1 | 1 | | | | | | | **1** | **1** |

Table 6 shows the number of male and female SAS doctors in various ethnic origin categories defined by specialty. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. This table shows the opposite trend to consultants in that 36% of the SAS workforce are 'White British' (16 are White British and 30 (64%) are non-White British). When considering BAME SAS doctors, 22 are from the EU and 22 are from Asia and Africa or elsewhere (50/50% respectively). In contrast to consultants, the male/female split in BAME areas is (50/50% respectively) whereas the EU workforce is highly biased towards females (27% males/73% females).

## Full Time / Part Time

**Table 7**

| **Consultant** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **D&D** | | **Tees** | | **NY** | | **Forensic** | | **Total** | |
| | Male | Female | Male | Female | Male | Female | Male | Female | M | F |
| Full Time | 25 | 14 | 24 | 12 | 16 | 6 | 13 | 7 | **79** | **38** |
| Part Time | 7 | 14 | | 5 | 8 | 7 | 2 | | **18** | **25** |
| **Specialty Doctors** | | | | | | | | | | |
| Full Time | 8 | 4 | 3 | 3 | 1 | 3 | 3 | 2 | **15** | **12** |
| Part Time | 1 | 4 | | 6 | | 4 | 1 | 1 | **2** | **15** |

Table 7 shows the number of male and female consultants / SAS doctors who are currently working full or part time defined by locality. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. This shows that overall, almost half (46%) of the career grade workforce are full time males with only a quarter (25%) of females in full time positions. In addition, only 9% of males and 20% of females are working part time. The number of part time workers could increase over the next few years due to the introduction of flexible training options open to all junior doctors.

**Table 8**

| Consultant | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AMH | | CYPS | | MHSOP | | LD | | Forensic MH | | Forensic LD | | Total | |
| | M | F | M | F | M | F | M | F | M | F | M | F | **M** | **F** |
| Full Time | 37 | 13 | 9 | 8 | 15 | 8 | 5 | 2 | 9 | 3 | 4 | 4 | **79** | **38** |
| Part Time | 6 | 6 | 8 | 12 | | 4 | 2 | 3 | 1 | | 1 | | **18** | **25** |
| **Specialty Doctors** | | | | | | | | | | | | | | |
| Full Time | 6 | 5 | | 2 | 6 | 3 | | | 2 | 2 | 1 | | **15** | **12** |
| Part Time | 1 | 5 | | 3 | | 5 | | 1 | | | 1 | 1 | **2** | **15** |

Table 8 shows the number of male and female consultants / SAS doctors who are currently working full or part time defined by specialty. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. Of interest is the high numbers of part time staff in CYPS (55% part time compared to 45% full time).

# Section 3: Vacancies

This section considers the number of current vacancies in the trust and the plans for recruitment, including whether a locum is covering at present.

| Table 1 | D&D | Tees | NY | Forensic | Total |
|---|---|---|---|---|---|
| Consultant | 5 | 4 | 2 | 1 | 13 |
| SAS | 2 | 2 | 2 | 1 | 7 |

Table 1 above shows the current vacancies in each directorate. Interestingly, the number of SAS vacancies has increased from 1 to 7 from last quarter, which could be due to doctors passing exams and gaining places on the higher training schemes.

| Table 2 | AMH | CYPS | MHSOP | LD | FMH | FLD | Total |
|---|---|---|---|---|---|---|---|
| Consultant | 5 | 3 | 4 | | 1 | | 13 |
| SAS | 4 | 2 | | | | 1 | 7 |

Table 2 above shows the current vacancies in each specialty. LD remains with no vacant positions.

## Vacancy Breakdown

**Table 3**

| Vacancies | Locum in place | Times Advertised | Date of Advert | Date of Interview | Appt made | Start date |
|---|---|---|---|---|---|---|
| Consultant in AMH (Inpatient / Crisis) RPH | Agency Locum | 0 | | | | |
| Consultant in AMH (Inpatient / Crisis) Sandwell Park | Trust Locum | 2 | 28/02/15 | 27/04/15 | | 27/04/15 |
| Consultant in AMH (PICU) RPH | No | 0 | | | | |
| Consultant in Liaison North Tees | No | 1 | 06/12/14 | 06/02/15 | Yes | 01/05/15 |
| Consultant in CYPS The Ridings, Redcar | No | 1 | 07/03/15 | 29/04/15 | No | |
| Consultant in CYPS Viscount House, Stockton | No | 0 | | | | |
| Consultant in MHSOP Woodside, Middlesbrough | Agency Locum | 2 | 24/01/15 | 18/03/15 | Yes | 05/08/15 |
| Specialty Doctor in CYPS Viscount House, Stockton | No | 1 | 23/05/15 | 30/06/15 | Yes | 05/08/15 |
| Senior Specialty Doctor in CYPS (specialist in Paediatrics) Viscount House, Stockton | No | 0 | | | | |

| Vacancies | Locum in place | Times Advertised | Date of Advert | Date of Interview | Appt made | Start date |
|---|---|---|---|---|---|---|
| Consultant in AMH (Community Eating Disorders) Imperial House | Agency Locum | 0 | | | | |
| Consultant in AMH (Substance Misuse) LRH | No | 1 | 20/06/15 | 04/08/15 | | |
| Consultant in CYPS Acley Centre, South Durham | Subs Cons | 0 | | 28/09/15 | | |
| Consultant in MHSOP Easington | Trust Locum | 4 or 5 | 24/01/15 | 18/03/15 | No | |
| Consultant in MHSOP (Liaison) LRH | No | 3 or 4 | 24/01/15 | 18/03/15 | No | |
| Specialty Doctor in AMH Crisis, West Park | Subs SAS | 0 | | | | |
| Specialty Doctor in AMH PICU, Rehab, West Park | Trust Locum | 0 | | | | |
| Consultant in AMH (Working Age Psychiatry) Ellis Ct, Sbr | Agency Locum | 2 | 28/02/15 | 27/04/15 | No | |
| Consultant in MHSOP Cross Lane Hospital / Malton | Trust Locum | 1 | 13/06/15 | 30/07/15 | | |
| Consultant in MHSOP Whitby | Acting Cons | 0 | | | | |
| Consultant in CYPS (Tier 4) West Lane Hospital | No | 2 | 07/03/15 | 29/04/15 | No | |
| Consultant in CYPS (6PA) Brompton House | No | 2 | 22/11/14 | 22/01/15 | Yes | 01/04/15 |
| Consultant in Forensic (Forensic Mental Health) RPH | Trust Locum | 1 | 14/02/15 | 09/04/15 | Yes | 09/04/15 |
| Consultant in Forensic (Forensic Mental Health), RPH | Subs Cons | 0 | | | | |
| Specialty Doctor in Forensic (Forensic LD), RPH | Subs SAS | 1 | 20/06/15 | 27/07/15 | | |

Table 3 shows the breakdown of each vacancy in the Trust and the number of times the post has been advertised (including any current adverts).

The table below shows the recruitment activity in this period (April to June 2015). Within this period 4 posts were advertised and recruitment has been largely successful.

Table 4

| Vacancies advertised | Times advertised | No of candidates applied | No of candidates shortlisted | Appointment made |
|---|---|---|---|---|
| Consultant in AMH Crisis / IHTT Roseberry Park | 2 | 1 | 1 | Yes, but then moved to Foxrush via job planning |
| Consultant in AMH Crisis / IHTT Sandwell Park | 2 | 1 | 1 | Yes |
| Consultant in AMH North Yorkshire | 2 | 1 | 1 | No |
| Consultant in Forensic MH Roseberry Park | 1 | 1 | 1 | Yes |
| Specialty Doctor CYPS, Viscount House | 1 | 2 | 2 | Yes |

Table 4 shows an 80% fill rate on the jobs advertised in this period.

# Section 4: Sickness

## Doctors on Long Term Sick Leave by Locality

Figure 1

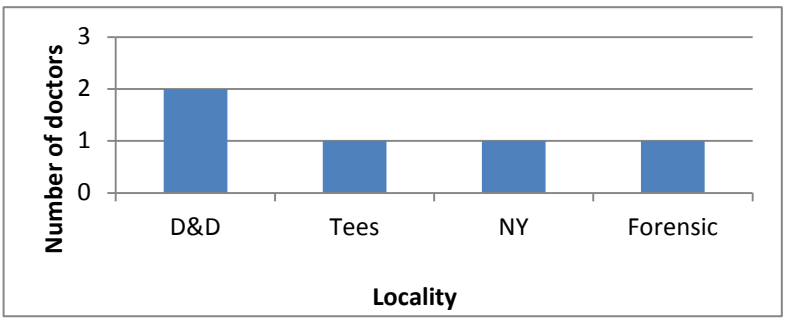



Figure 1 shows the number of doctors on long term sick (includes 3 consultants, 2 SAS). Three out of the five doctors from last quarter remain on long term sick leave.

## Reasons for Sickness Absence

Figure 2

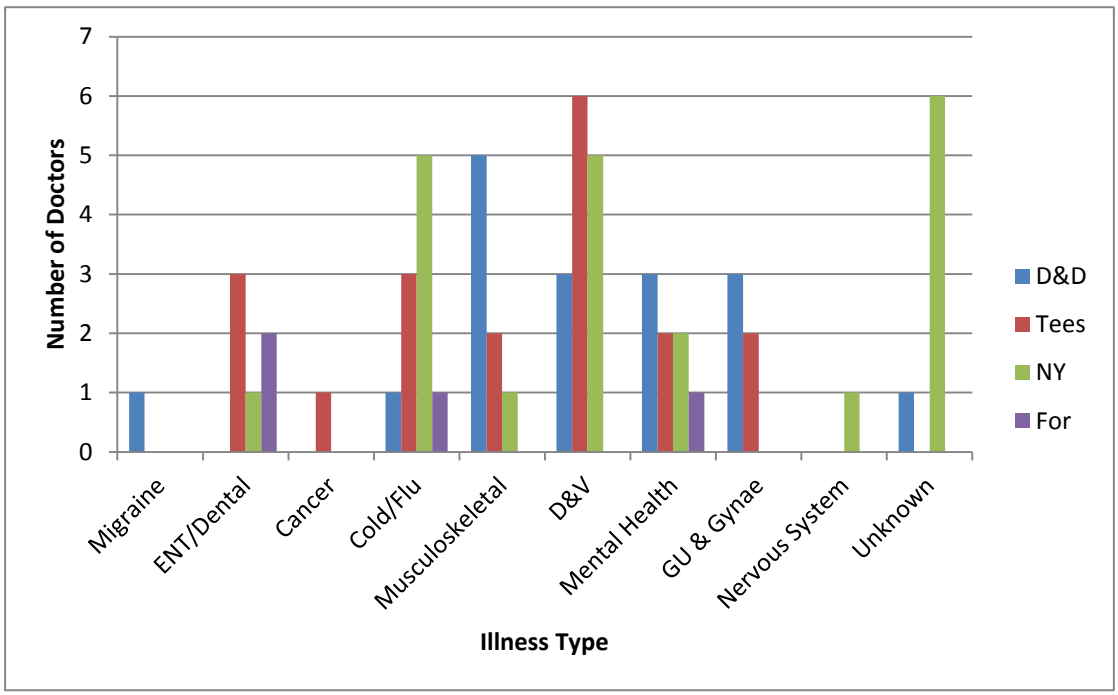



Figure 2 shows the reasons for sickness absence (including long term sickness) during the period April to June 2015. This includes all grades of doctor except agency locums. Interestingly, there are a high number of 'diarrhoea and vomiting' episodes in Teesside and North Yorkshire localities. There are also a high number of musculoskeletal problems in the Durham and Darlington locality. Overall, 489 days were lost due to sickness (60 days more than last quarter) out of which 177 were for short term illnesses and 312 were for long term illnesses.

# Section 5: Appraisals and Revalidation

### Consultants

| Table 1 | D&D | Tees | NY | For | Total |
|---|---|---|---|---|---|
| **Appraisals Due** | 9 | 5 | 3 | 2 | 19 |
| **Appraisals Actual** | 9 | 5 | 2 | 2 | 18 |

Table 1 shows the number of consultant appraisals that were due between 1st April 2015 and 30th June 2015 and how many were actually completed. The total number is broken down into locality.

| Table 2 | D&D | Tees | NY | For | Total |
|---|---|---|---|---|---|
| **Revalidation Due** | 5 | 5 | 3 | 3 | 16 |
| **Revalidation Actual** | 5 | 4 | 3 | 3 | 15 |

Table 2 shows the number of consultants who were due revalidation between 1st April 2015 and 30th June 2015 and those who were successfully revalidated. The numbers are broken down into locality.

### SAS

| Table 3 | D&D | Tees | NY | For | Total |
|---|---|---|---|---|---|
| **Appraisals Due** | 1 | 2 | 1 | 2 | 6 |
| **Appraisals Actual** | 1 | 1 | 1 | 2 | 5 |

Table 3 shows the number of SAS doctor appraisals that were due between 1st April 2015 and 30th June 2015 and how many were actually completed. The total number is broken down into locality.

| Table 4 | D&D | Tees | NY | For | Total |
|---|---|---|---|---|---|
| **Revalidation Due** | 3 | 0 | 2 | 0 | 5 |
| **Revalidation Actual** | 3 | 0 | 2 | 0 | 5 |

Table 4 shows the number of SAS doctors who were due revalidation between 1st April 2015 and 30th June 2015 and those who were successfully revalidated. The numbers are broken down into locality.

### Trust Doctor

| Table 5 | D&D | Tees | NY | For | Total |
|---|---|---|---|---|---|
| **Appraisals Due** | 0 | 0 | 0 | 0 | 0 |
| **Appraisals Actual** | 0 | 0 | 0 | 0 | 0 |

Table 3 shows the number of Trust doctor appraisals that were due between 1st April 2015 and 30th June 2015 and how many were actually completed. The total number is broken down into locality.

| Table 6 | D&D | Tees | NY | For | Total |
|---|---|---|---|---|---|
| **Revalidation Due** | 0 | 0 | 0 | 0 | 0 |
| **Revalidation Actual** | 0 | 0 | 0 | 0 | 0 |

Table 4 shows the number of Trust doctors who were due revalidation between 1st April 2015 and 30th June 2015 and those who were successfully revalidated. The numbers are broken down into locality.

# Section 6: Turnover

This section considers the number of doctors who have commenced in the Trust between 1st June 2015 and 30th June 2015. It also highlights the number of doctors leaving the Trust and their leaver destination.

## New Starters vs Leavers by Locality

| Table 1 | D&D | Tees | NY | Forensic | Total |
|---|---|---|---|---|---|
| New Starters | 4 | | | | 4 |
| Leavers | | | | 1 | 1 |

Table 1 highlights the number of new starters against the number of leavers. Again, this includes all types of staff except agency locums. This shows there has been considerably less activity to last quarter (9 starters, 5 leavers).

## New Starters vs Leavers by Specialty

| Table 2 | AMH | CYPS | MHSOP | LD | FMH | FLD | Total |
|---|---|---|---|---|---|---|---|
| New Starters | 2 | 1 | 1 | | | | 4 |
| Leavers | | | | | | 1 | 1 |

Table 2 shows the number of new starters against the number of leavers defined by specialty. This includes all types of staff, eg permanent, locum, trust doctors – except agency locums.

## New Starters vs Leavers Grade Breakdown

| Table 3 | Consultants | SAS | Trust Doctors |
|---|---|---|---|
| New Starters | 4 | | |
| Leavers | | 1 | |

Table 3 shows the number of new starters against the number of leavers defined by grade. This includes all types of staff, eg permanent, locum, trust doctors – except agency locums.

## Leaver Destination by Locality

| Table 4 | D&D | Tees | NY | Forensic | Total |
|---|---|---|---|---|---|
| Flexible Retirement | | | | | |
| Fully Retired | | | | | |
| Moved Abroad | | | | | |
| Needed to Relocate | | | | 1 | 1 |
| Joined NHS Trust | | | | | |
| Joined Train Scheme | | | | | |

Table 4 shows the destination of doctors after leaving the Trust, defined by locality. This includes all types of staff, eg permanent, locum, trust doctors – except agency locums. The age of the leaver is 44 and is moving to be with husband who has a permanent position in Liverpool.

## Leaver Destination by Specialty

| Table 5 | AMH | CYPS | MHSOP | LD | FMH | FLD | Total |
|---|---|---|---|---|---|---|---|
| **Flexible Retirement** | | | | | | | |
| **Fully Retired** | | | | | | | |
| **Moved Abroad** | | | | | | | |
| **Needed to Relocate** | | | | | | 1 | 1 |
| **Other NHS Trust** | | | | | | | |
| **Joined Training Scheme** | | | | | | | |

Table 5 shows the destination of doctors after leaving the Trust, broken down by specialty. This includes all types of staff, eg permanent, locum, trust doctors – except agency locums.

## Leaver Destination by Grade

| Table 6 | Consultants | SAS | Trust Doctors |
|---|---|---|---|
| **Flexible Retirement** | | | |
| **Fully Retired** | | | |
| **Moved Abroad** | | | |
| **Needed to Relocate** | | 1 | |
| **Other NHS Trust** | | | |
| **Joined Training Scheme** | | | |

Table 6 shows the destination of doctors after leaving the Trust, broken down by grade. This includes all types of staff, eg permanent, locum, trust doctors – except agency locums.

# Section 7: Mind the Gap Payments

This section includes the number of extra PA payments that are being made within 'Mind the Gap', eg for providing cover during sickness or vacancies. It is broken down into locality and specialty.

| Table 1 | AMH | CYPS | MHOSP | LD | FMH | FLD | Total |
|---|---|---|---|---|---|---|---|
| **D&D** | 7.5 | 2 | 1 | | | | 10.5 |
| **Teesside** | 5 | 15.5 | | 2 | | | 22.5 |
| **NY** | 1 | 4 | 4 | | | | 9 |
| **Forensic** | | | | | 12 | 8.5 | 20.5 |
| **Total** | 13.5 | 21.5 | 5 | 2 | 12 | 8.5 | **62.5** |

Table 1 shows the number of additional PAs under Mind the Gap. This shows that additional PAs in CYPS have decreased from last quarter, however, remains the same in Teesside where there are vacancies. Additional PAs in AMH have increased due to Teesside reducing from 2 agency locums to 1 and in Forensic Services due to sickness and maternity cover.

# Section 8: Medical Education

**Creation of a Feeder Scheme for Core Training**
EMT recently discussed the issue of poor recruitment into core and higher training programmes. There is an ongoing concern that both the region and the specialty of psychiatry continues to struggle to attract sufficient numbers into training, this despite concerted efforts to tackle this agenda.

Last year the Trust developed an approach to encourage Trust grade doctors to work in the Trust for a minimum one year contract and offered a tailored development programme and relatively small relocation allowance. The doctors who were interested in the scheme were generally equivalent to that of a foundation two stage doctor. To date, this approach has proved relatively successful and we currently have 11 doctors in post. Without these, the vacancies would have resulted in agency usage given they are predominantly in Yorkshire and the small rota sizes. A scheme such as this therefore has two benefits. One to fill vacant posts for service and secondly to encourage these doctors to apply for core training and remain in the region.

It was agreed that the Trust would formalise this approach and create a robust support structure that includes tutor support and mentorship and overseen for quality assurance by medical development as with other formally recognised training programmes. This is especially important as the scheme is likely to attract junior colleagues who studied overseas as students and require more support.

The Trust will now work in partnership with NTW on this initiative and look to Europe to attract doctors that would be interested in this scheme.

**2015 Annual Deanery Quality Management Visit (ADQM)**
Following the recent visits outlined in the last report, HEY&H held their annual visit in York to quality assure and assess the delivery of junior doctor programmes in TEWV. They reflected that the event was well organised and there was good engagement from the Trust, trainees and trainers with all units represented. In general feedback was excellent with trainees describing being well supported, accessing a wide case mix and having good teaching. They informed us that all trainees and trainers would be comfortable for family and friends to be treated at the Trust and the vast majority would recommend their post to a colleague.

They found that the foundation doctors interviewed were having a good range of experience with opportunities to reflect following outpatient clinics. The Higher trainees had opportunities to lead and received targeted training.

Registrars reported they had access to long psychotherapy cases and apart from the lack of acute psychiatry experience in some quieter units, would recommend posts.

**2015 GMC Trainee Survey**
Each year the junior doctors on placement in the Trust complete a survey about their training. Please find overleaf a report looking in more detail at the survey results for registrars, GP registrars and foundation doctors.

It is particularly important for the Trust to use this positive feedback to try and help in our recruitment drive.

# GMC Trainee Survey Results 2015

The GMC undertakes a national trainee survey each year. This year the response rate was high with HENE having a response rate of 97.2% and HEY&H a response rate of 98.5%.

The responses from the survey provides the Trust with an opportunity to triangulate data with other sources of feedback including that from Schools of Psychiatry, Foundation Programmes and mid-term reviews with doctors. It allows the faculty of medical education to celebrate success and more importantly identify areas where improvement is necessary and this informs the quality improvement plan for the forthcoming year.

The GMC survey has fourteen indicators. These are:

- Overall satisfaction
- Clinical supervision
- Clinical supervision out of hours
- Handover
- Induction
- Adequate experience
- Supportive environment
- Workload
- Educational supervision
- Access to educational resources
- Feedback
- Local teaching
- Regional teaching
- Study leave

The feedback in this report is separated into comparison sets of registrars, foundation doctors, GP registrars and senior registrars with comparisons made against local providers and national benchmarking of programmes. Overall, the Trust's position is very positive.

In fact HENE announced that they were the number one ranked LETB in the country, excluding the military deanery, and when combining the feedback from all groups of junior doctors on placement at TEWV in the HENE area, this Trust was number one ranked from the feedback received in the GMC survey.

**Regional Rank by Trust**

This report provides results for all trainees based on their North East Trust for the 2015 National Training Survey.
For example: Northumbria Healthcare Foundation Trust trainees compared to all other North East trainees.

| Trust / Board | Access to Educational Resources | Adequate Experience | Clinical Supervision | Clinical Supervision out of hours | Educational Supervision | Feedback | Handover | Induction | Local Teaching | Overall Satisfaction | Regional Teaching | Study Leave | Supportive environment | Work Load |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| City Hospitals Sunderland NHS Foundation Trust | 5 | 9 | 8 | 6 | 5 | 7 | 5 | 3 | 9 | 8 | 4 | 11 | 9 | 3 |
| County Durham and Darlington NHS Foundation Trust | 9 | 8 | 9 | 8 | 9 | 10 | 4 | 7 | 7 | 9 | 10 | 7 | 7 | 8 |
| Gateshead Health NHS Foundation Trust | 2 | 1 | 7 | 3 | 3 | 6 | 8 | 8 | 10 | 3 | 11 | 5 | 3 | 6 |
| North Cumbria University Hospitals NHS Trust | 11 | 10 | 10 | 11 | 4 | 8 | 2 | 4 | 3 | 10 | 8 | 10 | 11 | 9 |
| North Tees and Hartlepool NHS Foundation Trust | 4 | 2 | 4 | 4 | 1 | 3 | 1 | 6 | 4 | 4 | 5 | 7 | 5 | 11 |
| Northumberland, Tyne and Wear NHS Foundation Trust | 3 | 4 | 1 | 7 | 11 | 2 | 10 | 11 | 2 | 2 | 2 | 2 | 4 | 2 |
| Northumbria Healthcare NHS Foundation Trust | 6 | 6 | 6 | 9 | 10 | 9 | 7 | 2 | 4 | 7 | 6 | 9 | 2 | 4 |
| South Tees Hospitals NHS Foundation Trust | 7 | 7 | 3 | 1 | 7 | 4 | 6 | 5 | 6 | 5 | 9 | 4 | 6 | 7 |
| South Tyneside NHS Foundation Trust | 10 | 11 | 11 | 10 | 6 | 11 | 9 | 10 | 11 | 11 | 3 | 3 | 8 | 5 |
| Tees, Esk and Wear Valleys NHS Foundation Trust | 1 | 3 | 2 | 5 | 2 | 1 | 11 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| The Newcastle Upon Tyne Hospitals NHS Foundation Trust | 8 | 5 | 5 | 2 | 8 | 5 | 3 | 9 | 8 | 6 | 7 | 6 | 10 | 10 |

The Trusts are ranked by highest score from 1 to 11 against the GMC domains and you are able to identify TEWV is ranked as the highest ranked in 9 of the GMC domains. This analysis does not provide an indication of the variation from highest ranking to the lowest.

## Registrars (Core Training in Psychiatry)

The table below illustrates the GMC survey outcomes from 2012 for all registrars in the Trust. The figures in brackets compare the Trust score to the national average.

**Figure 1**

| Indicators | Registrars 2015 | Registrars 2014 | Registrars 2013 | Registrars 2012 | Average of all Registrars in Psychiatry |
|---|---|---|---|---|---|
| Overall satisfaction | 87 (+3) | 88 | 83 | 80 | 84 |
| Clinical supervision | 93 (+1) | 94 | 93 | 90 | 92 |
| Clinical supervision out of hours | 89 (+1) | N/A | N/A | N/A | 88 |
| Handover | 49 (-9) | 52 | 47 | 41 | 58 |
| Induction | 93 (+8) | 93 | 89 | 86 | 85 |
| Adequate experience | 86 (+2) | 88 | 82 | 79 | 84 |
| Supportive environment | 82 (+6) | N/A | N/A | N/A | 76 |
| Workload | 57 (-3) | 54 | 52 | 52 | 54 |
| Educational supervision | 95 (+6) | 96 | 92 | 95 | 89 |
| Access to educational resources | 77 (+6) | 74 | 71 | 69 | 71 |
| Feedback | 88 (+3) | 86 | 87.5 | 83 | 85 |
| Local teaching | 71 (-2) | 73 | 71 | 72 | 73 |
| Regional teaching | 81 (+4) | 79 | 77 | 72 | 77 |
| Study leave | 77 (+6) | 77 | 74 | 74 | 71 |

## Breakdown of questions

The reporting tool allows us to understand some of the areas where we have not scored so positively and the questions that were posed by the survey. Handover was the main issue.

**Registrar Handover**

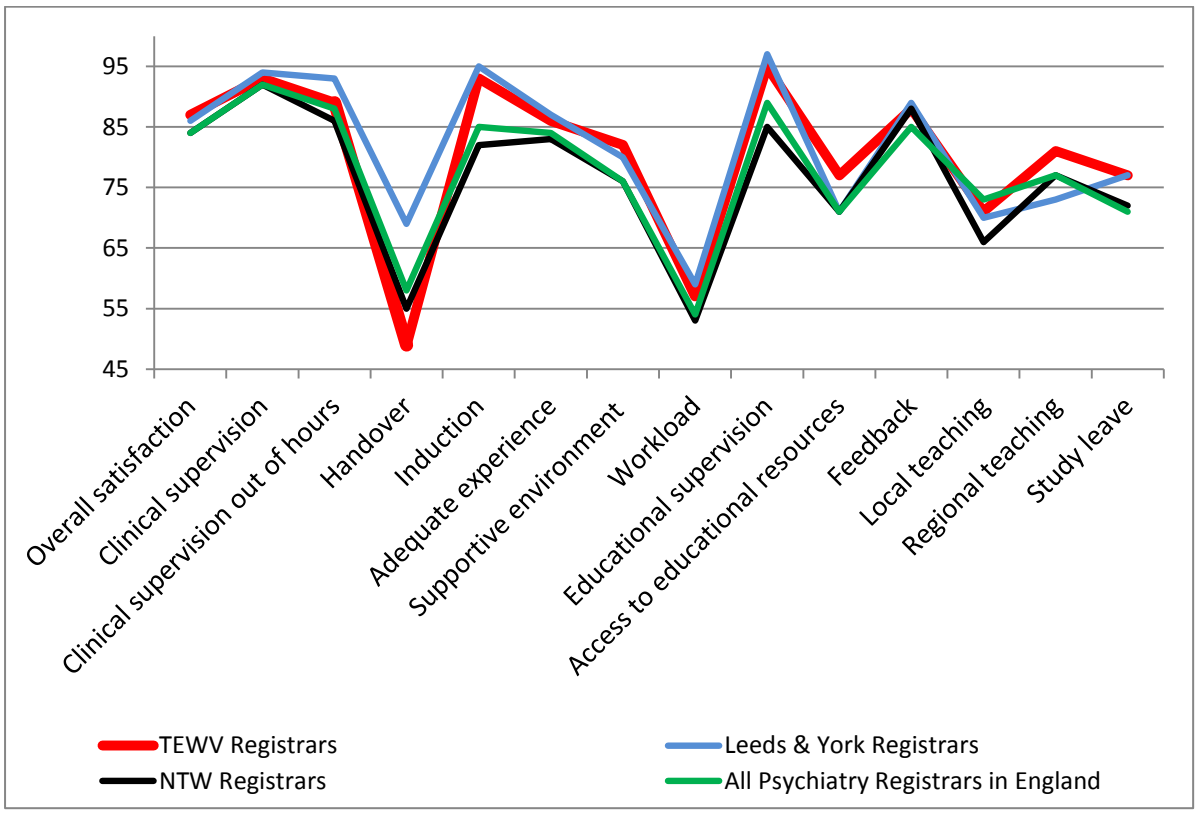
| Which of the following best described handover arrangements before night duty? | |
|---|---|
| Not applicable | 27.03 |
| Informal | 10.81 |
| No arrangements | 10.81 |

| Which of the following best described handover arrangements after night duty? | |
|---|---|
| Not applicable | 13.51 |
| Informal | 8.11 |
| No arrangements | 10.81 |

Since the survey results were published, we have asked each locality to re-enforce the handover protocol and ensure it is discussed in more detail at induction. It should be noted that some doctors answered ‘not applicable’ because there are times where doctors receive no calls out of hours and there has been nothing to handover.

Figure 2 outlines the comparisons in the 2015 survey for registrars based in TEWV, Leeds and York Partnership Trust and Northumbria Tyne and Wear Trust and the score for all registrars in psychiatry across the UK.

**Figure 2**




## Key issues

Whilst the Trust has increased in four of the fourteen indicators from 2014, it has also decreased slightly in six. The majority of these are minor decreases but we should note the variation.

Interestingly, local teaching has decreased from 2014 despite a new structure being introduced within Teesside and York that has received excellent feedback to date.

Junior doctor rooms were modernised and facilities improved recently in some of the localities and a review of PC access was undertaken in February. This may well have impacted on the positive feedback for educational resources.

Whilst registrars from Leeds and York Partnership Trust rate well and received slightly more favourable feedback compared to TEWV, registrars within TEWV have the highest overall satisfaction and are above the average of registrars in psychiatry nationally.

## GP Registrars

The table below illustrates the survey outcomes for GP Registrars on placement in psychiatry within TEWV from 2012. The scores in brackets are the changes from the feedback last year.

**Figure 3**

| Indicators | TEWV 2015 | TEWV 2014 | TEWV 2013 | Psychiatry Nationally 2015 | Regional GP Scheme 2015 |
|---|---|---|---|---|---|
| Overall satisfaction | 86 (+8) | 78 | 85 | 80 | 83 |
| Clinical supervision | 93 (+5) | 88 | 91 | 87 | 91 |
| Clinical supervision out of hours | 88 | N/A | N/A | 83 | 90 |
| Handover | 46 (-9) | 55 | 44 | 53 | 71 |
| Induction | 95 (+14) | 81 | 87 | 83 | 88 |
| Adequate experience | 88 (+8) | 80 | 82 | 79 | 84 |
| Supportive environment | 87 | N/A | N/A | 77 | 78 |
| Workload | 74 (+10) | 64 | 72 | 62 | 49 |
| Educational supervision | 98 (+7) | 91 | 97.5 | 90 | 92 |
| Access to educational resources | 86 (+12) | 74 | 80 | 71 | 71 |
| Feedback | 92 (+4) | 88 | 90 | 80 | 80 |
| Local teaching | 76 (+3) | 73 | 74 | 70 | 65 |
| Regional teaching | 91 (+7) | 84 | 90 | 76 | 73 |
| Study leave | 71 (+2) | 69 | 87 | 77 | 72 |

## Key Issues

There has been an increase in eleven of the fourteen indicators for GP Registrars. This has been a significant improvement from the 2014 results and is very positive.

The feedback shows that overall GP Registrars on placement at TEWV score significantly higher than on placement in other areas of the GP Schemes in our LETB areas.

Last year the Trust was commended by the GP Training Scheme for the quality of its training and the feedback it had received from the GMC survey. The data is a further improvement on this benchmark.

The GMC have rated the feedback as positive outliers against the mean in:

- access to educational resources
- feedback
- regional teaching
- supportive environment
- workload

The issues relating to handover are those as outlined earlier in the Registrar section.

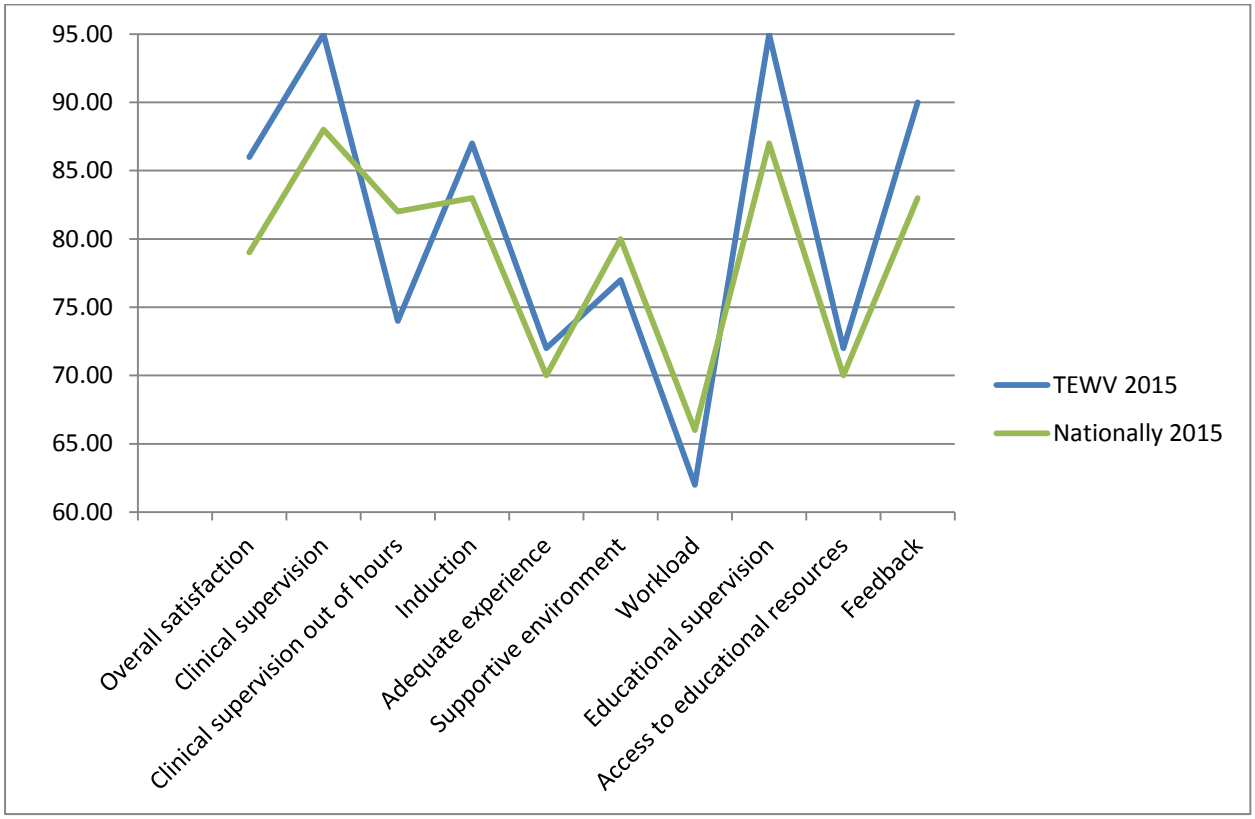
## Foundation Doctors

This section considers feedback from foundation doctors undertaking four month placements in psychiatry. The Trust offers foundation one and foundation two placements. Unfortunately there is no data available from other Trusts for comparison at present and this could be due to the low number of doctors completing the survey.

The table below illustrates the survey outcomes for foundation one doctors on placement in psychiatry.

**Figure 4.1 Foundation One**

| Indicators | TEWV 2015 | TEWV 2014 | Nationally 2015 |
|---|---|---|---|
| Overall satisfaction | 86 | 79 | 79 |
| Clinical supervision | 95 | 92 | 88 |
| Clinical supervision out of hours | 74 | N/A | 82 |
| Handover | N/A | N/A | N/A |
| Induction | 87 | 78 | 83 |
| Adequate experience | 72 | 63 | 70 |
| Supportive environment | 77 | N/A | 80 |
| Workload | 62 | 64 | 66 |
| Educational supervision | 95 | 86 | 87 |
| Access to educational resources | 72 | 80 | 70 |
| Feedback | 90 | 80 | 83 |



## Breakdown of questions

We are able to understand further some of the areas where foundation one doctors have not scored so positively and the questions that were posed.

| How would you rate the intensity of your work by day, in this post? | |
|---|---|
| Very light | 0 |
| Light | 40 |
| About right | 40 |
| Heavy | 20 |
| Very heavy | 0 |
| **Overall how would you rate the educational resources in this post?** | |
| Very good | 20 |
| Good | 60 |
| Neither good or poor | 20 |
| Poor | 0 |
| Very poor | 0 |

The table below illustrates the survey outcomes for foundation two doctors on placement in psychiatry. The score in brackets compares TEWV against the national average.

**Figure 4.2 Foundation Two**

| Indicators | TEWV 2015 | TEWV 2014 | Nationally 2015 All Specialties |
|---|---|---|---|
| Overall satisfaction | 78 (-3) | 81 | 81 |
| Clinical supervision | 91 | 91 | 89 |
| Clinical supervision out of hours | 90 | N/A | 85 |
| Handover | 61 (+2) | 59 | 52 |
| Induction | 94 | 94 | 86 |
| Adequate experience | 76 (-2) | 78 | 78 |
| Supportive environment | 80 | N/A | N/A |
| Workload | 56 (+3) | 53 | 64 |
| Educational supervision | 93 (-1) | 94 | 90 |
| Access to educational resources | 71 (-4) | 75 | 72 |
| Feedback | 90 (+2) | 88 | 83 |
| Study leave | 90 (+5) | 85 | 79 |

## Breakdown of questions

We are able to understand further some of the areas where foundation two doctors have not scored so positively and the questions that were posed.

| How would you rate the overall teaching in this post? | |
|---|---|
| Excellent | 29.73 |
| Good | 56.76 |
| Fair | 10.81 |
| Poor | 2.70 |
| Very poor | 0 |

| How would you rate the quality of clinical supervision? | |
|---|---|
| Excellent | 56.76 |
| Good | 35.14 |
| Fair | 8.11 |
| Poor | 0 |
| Very poor | 0 |
| **How would you rate the quality of experience in this post?** | |
| Excellent | 51.35 |
| Good | 35.14 |
| Fair | 13.51 |
| Poor | 0 |
| Very poor | 0 |
| **How useful do you feel this post will be for your future career?** | |
| Very useful | 51.35 |
| Useful | 37.84 |
| Fairly useful | 5.41 |
| Not very useful | 5.41 |
| Useless | 0 |
| **How confident are you that this post helped you acquire the competencies you needed at that particular stage of training?** | |
| Very confident | 10 |
| Fairly confident | 80 |
| Neutral | 10 |
| Not very confident | 0 |

## Key Issues

Overall the survey results from the foundation doctors has improved since 2014.

The Foundation year one doctors reported inadequate experience in 2014 and this has improved significantly along with overall satisfaction, induction and feedback. However, the workload and access to educational resources indicators have decreased and we may need to better inform doctors of the resources available. This will be shared with faculty members responsible for foundation training to consider further.

The GMC have rated the feedback as positive outliers against the mean for foundation one doctors in:

- clinical supervision
- feedback
- workload

The score for clinical supervision out of hours score is a concern. Supervision is always available through a Consultant, sometimes with support from an SpR, but this senior doctor is not resident and provides advice and guidance over the telephone and attends in person when necessary.

The faculty will also need to consider why the score for supportive environment is lower than it would expect.

## Senior Registrars

The table below illustrates the survey results for senior registrars within our own Trust.

**Figure 5**

| Indicators | TEWV 2015 | TEWV 2014 |
|---|---|---|
| Overall Satisfaction | 87 (-1) | 88 |
| Clinical Supervision | 94 | 94 |
| Clinical supervision out of hours | 92 | N/A |
| Handover | 44 (+3) | 41 |
| Induction | 85 (-1) | 86 |
| Adequate Experience | 89 | 89 |
| Work Load | 56 (+1) | 55 |
| Educational Supervision | 87 | 87 |
| Access to Educational Resources | 72 (-1) | 73 |
| Feedback | 85 (-1) | 86 |
| Local Teaching | 67 (-1) | 68 |
| Regional Teaching | 72 (-1) | 73 |
| Study Leave | 84 | 84 |
| Supportive environment | 79 | N/A |

## Key Issues

The table above demonstrates that feedback has slightly decreased in six of the indicators compared to 2014. We are still waiting for further information from HENE on the national average figures for this group of doctors. The faculty will also need to consider why the score for supportive environment is lower than it would expect.

Recently the School of Psychiatry in HENE published the findings of their own survey and this showed a high level of satisfaction from SpR's. The School report concluded:

**Positive / notably practices:**

- High levels of recommendation of the training.
- Promoting skills and competencies for clinical assessment, management and MDT working.
- Very good access to supervision (clinical, educational and out of hours)
- Excellent access to special interest sessions, research and study leave
- General awareness about safety systems improving
- There was good access to audit.

**Concerns / challenges:**

- Potential concerns about safety in 136 Suites.
- Access to e-portfolio

## Overall Ranking - all Junior Doctors Placements

The table below compares data from our Trust, incorporating both LETB areas. It compares this data with that from Northumbria Tyne and Wear Trust, Leeds and York Partnership Trust, Sheffield Health & Social Care Trust and South London and Maudsley Trust.

The scores in brackets represent the difference in scores from TEWV.

**Figure 6**

| | **TEWV** | **Leeds** | **NTW** | **Sheffield** | **Maudsley** |
|---|---|---|---|---|---|
| Overall Satisfaction | 85 | 87 (+2) | 85 | **82 (-3)** | 87 (+2) |
| Clinical Supervision | 93 | 94 (+1) | 93 | **88 (-5)** | **92 (-1)** |
| Clinical Supervision out of hours | 90 | 92 (+2) | **89 (-1)** | **84 (-6)** | **88 (-2)** |
| Induction | 92 | 93 (+1) | **85 (-7)** | **86 (-6)** | **83 (-9)** |
| Adequate Experience | 85 | 89 (+4) | 85 | **81 (-3)** | 87 (+2) |
| Supportive environment | 82 | **81 (-1)** | **79 (-3)** | **74 (-8)** | **79 (-3)** |
| Educational Supervision | 95 | **94 (-1)** | **88 (-7)** | **93 (-2)** | **82 (-13)** |
| Access to Educational Resources | 77 | **71 (-6)** | **73 (-4)** | **65 (-7)** | 78 (+1) |
| Feedback | 88 | 90 (+2) | 88 | **87 (-1)** | **85 (-3)** |
| Local Teaching | 70 | **69 (-1)** | **67 (-3)** | **66 (-4)** | 77 (+7) |

**Figure 7**

The table below compares TEWV overall ranking for all junior doctor placements against the average scores in each of our neighbouring LETB's. This data is taken from averaging the scores from all training programmes across all specialties.

| | TEWV Average | HEY&H Average | HENE Average | HENW Average |
|---|---|---|---|---|
| Overall Satisfaction | 85 | 81 | 83 | 82 |
| Clinical Supervision | 93 | 89 | 91 | 89 |
| Clinical Supervision out of hours | 90 | 88 | 90 | 88 |
| Induction | 92 | 85 | 88 | 86 |
| Adequate Experience | 85 | 82 | 84 | 82 |
| Supportive environment | 82 | 76 | 78 | 76 |
| Work Load | 60 | 48 | 49 | 49 |
| Educational Supervision | 95 | 90 | 92 | 91 |
| Access to Educational Resources | 77 | 68 | 71 | 70 |
| Feedback | 88 | 78 | 80 | 78 |
| Local Teaching | 70 | 64 | 65 | 64 |

## Site Specific Outliers

**Figure 8**

| Site | Positive | Negative |
|---|---|---|
| Lanchester Road Hospital | • Induction<br>• Study leave | • Handover |
| The Friarage Hospital | • Induction | • Handover |
| North End House | • Overall satisfaction<br>• Clinical supervision<br>• Clinical supervision out of hours<br>• Induction<br>• Supportive environment<br>• Workload<br>• Access to educational resources<br>• Feedback<br>• Regional teaching | |
| Roseberry Park Hospital | • Access to educational resources | |
| Sandwell Park Hospital | • Induction<br>• Access to educational resources | |
| West Lane Hospital | • Clinical supervision<br>• Supportive environment<br>• Regional teaching | • Handover |

## Key Issues

Individual sites have been acknowledged as a positive outlier. North End House in particular reported good practice in nine indicators.

Lanchester Road, the Friarage and West Lane hospitals highlighted concerns around handover.

## Recommendations

The data from the GMC survey will be used to inform some of our themes of work in the forthcoming year and will be included in the quality improvement plan for 2015/16.

Immediate actions that arise from the data include:

1. A short survey has been developed in conjunction with a SpR representative that will help us to understand some of the lower scoring domains and prepare the Trust for the HENE School of Psychiatry visit later in the year.

2. Issues such as access to educational resources, I.T. facilities, handover and the expectations of clinical and educational supervision will be emphasised at induction.

3. The induction for foundation doctors on placement with the Trust will make clear the educational resources available to them.

4. The foundation steering group will be asked to explore the lower satisfaction level for foundation two doctors.

5. The trainee rep forum will discuss why clinical supervision out of hours may have rated relatively low in the survey.

6. Generally the feedback from the SpR group indicates that placements need to be improved. The School of Psychiatry takes greater ownership of this group of doctors and we must work with them to understand the feedback.

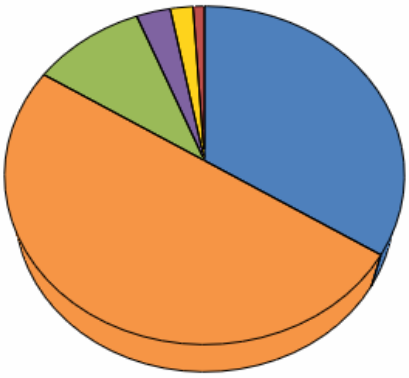
7. Medical development will strive to provide internal benchmarking of the GMC scores for the different localities as smaller trends can be hidden when looking at Trust level scores.

8. Examine GMC feedback from other mental health trusts and approach those who score highly in domains where this Trust does not.

9. Undertake inspections across the Trust for all 136 suites.

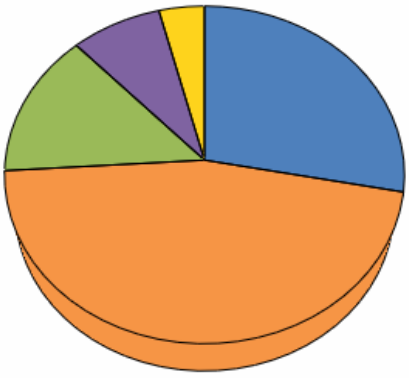
## Trust Wide

### 1 - How likely are you to recommend this organisation to friends and family if they needed care or treatment?



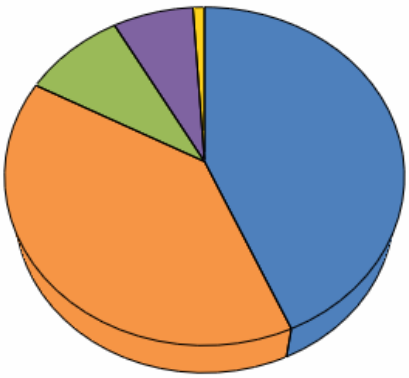
| Base | 3012 | |
|---|---|---|
| Extremely likely * | 1024 | 34% |
| Likely * | 1507 | 50% |
| Neither likely nor unlikely | 311 | 10% |
| Unlikely | 93 | 3% |
| Extremely unlikely | 48 | 2% |
| Don't know | 29 | 1% |

### 2 - How likely are you to recommend this organisation to friends and family as a place to work?



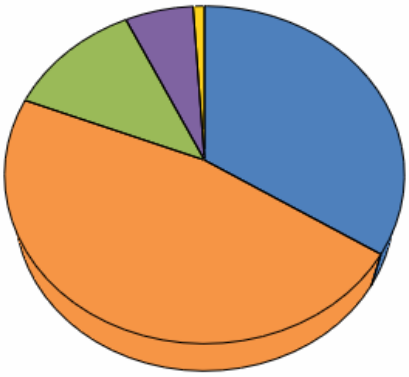
| Base | 3010 | |
|---|---|---|
| Extremely likely * | 830 | 28% |
| Likely * | 1396 | 46% |
| Neither likely nor unlikely | 416 | 14% |
| Unlikely | 239 | 8% |
| Extremely unlikely | 124 | 4% |
| Don't know | 5 | 0% |

## 3 - The care of patients/service users is my Trust's top priority.



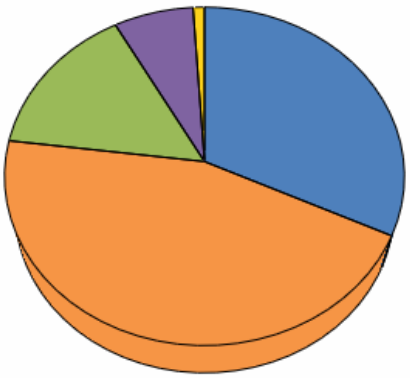
| | | |
|---|---|---|
| **Base** | **2998** | |
| Strongly agree * | 1284 | 43% |
| Agree * | 1182 | 39% |
| Neither agree nor disagree | 280 | 9% |
| Disagree | 214 | 7% |
| Strongly disagree | 38 | 1% |

## 4 - I am able to make suggestions to improve the work of my team/department.



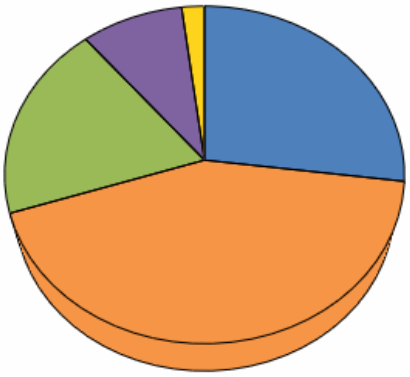
| | | |
|---|---|---|
| **Base** | **2884** | |
| Strongly agree * | 976 | 34% |
| Agree * | 1348 | 47% |
| Neither agree nor disagree | 357 | 12% |
| Disagree | 162 | 6% |
| Strongly disagree | 41 | 1% |

## 5 - There are frequent opportunities for me to show initiative in my role.



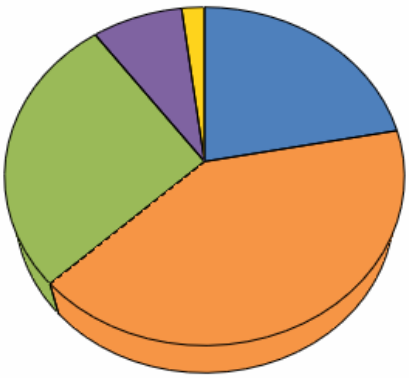
| | | |
|---|---|---|
| **Base** | **2967** | |
| Strongly agree * | 938 | 32% |
| Agree * | 1323 | 45% |
| Neither agree nor disagree | 443 | 15% |
| Disagree | 219 | 7% |
| Strongly disagree | 44 | 1% |

## 6 - I am able to make improvements happen in my area of work.



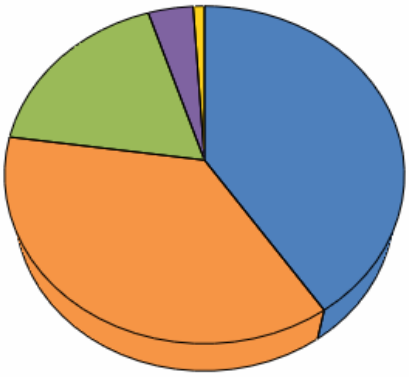
| | | |
|---|---|---|
| **Base** | **2933** | |
| Strongly agree * | 795 | 27% |
| Agree * | 1268 | 43% |
| Neither agree nor disagree | 554 | 19% |
| Disagree | 253 | 9% |
| Strongly disagree | 63 | 2% |

## 7 - I look forward to going to work.



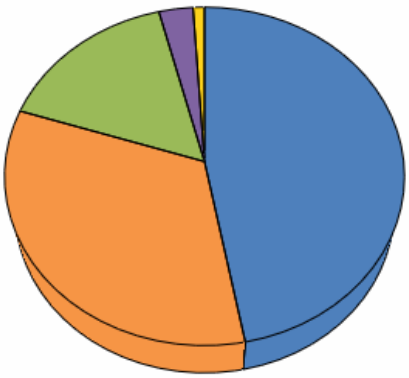
| | | |
|---|---|---|
| **Base** | **2987** | |
| Always * | 665 | 22% |
| Often * | 1232 | 41% |
| Sometimes | 802 | 27% |
| Rarely | 237 | 8% |
| Never | 51 | 2% |

## 8 - I am enthusiastic about my job.



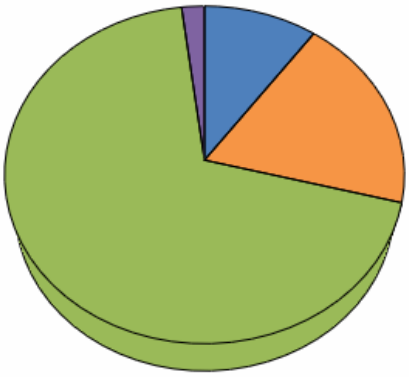
| | | |
|---|---|---|
| **Base** | **2966** | |
| Always * | 1203 | 41% |
| Often * | 1085 | 37% |
| Sometimes | 544 | 18% |
| Rarely | 114 | 4% |
| Never | 20 | 1% |

## 9 - Time passes quickly when I am working.



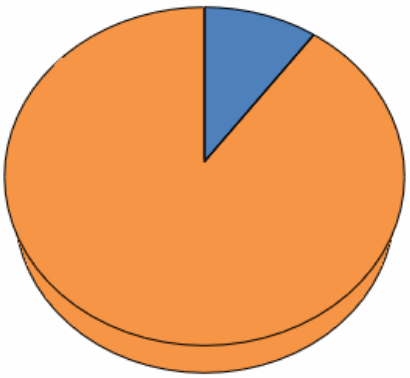
| | | | |
|---|---|---|---|
| | **Base** | **2974** | |
| | Always * | 1403 | 47% |
| | Often * | 978 | 33% |
| | Sometimes | 465 | 16% |
| | Rarely | 96 | 3% |
| | Never | 32 | 1% |

## 10 - Are you a smoker?



| | | | |
|---|---|---|---|
| | **Base** | **2984** | |
| | Yes | 288 | 10% |
| | Ex-smoker | 568 | 19% |
| | No | 2064 | 69% |
| | Prefer not to say | 64 | 2% |

**11 - If yes, would you like support at work to help you quit?**



| Base | 1007 | |
|---|---|---|
| Yes | 101 | 10% |
| No | 906 | 90% |

**Free Text Comments**

**How likely are you to recommend this organisation to friends and family if they needed care or treatment?**

**Extremely likely**

The Trust offers a fantastic service.

Compassionate and caring and with good skills.

Having worked with TEWV staff for the past five months, I am really impressed with how caring the nurses are.

Care is second to none and all individual circumstances are catered for.

Caring staff.

The ward is excellent and very supportive of recovery.

Because of their professionalism and excellent service.

I have friends and family members that have been seen professionally by members of the Trust and I can honestly say that the service they have always received has been 110%. I would definitely recommend TEWV to anyone needing their care or treatment.

The wards and sites I visit, staff are always caring and friendly.

From the short time I have worked in the Trust (4 months) it appears to be genuinely caring and has compassion for the users and families. Although there are demands which outweigh the resources available, these do seem to be developed keeping the user and family central to the thinking.

My main reason for my answer is that when my son eventually received care and treatment it was of a high standard.

I feel I work with like-minded people who care about others and their wellbeing.

Staff Experience – Friends and Family Test Quarter 1 2015

I am proud to work in this Trust and have only seen dedication to the highest standards of care so far. I am very happy in my role and believe in the values of the Trust.

As a Trust which has just achieved a GOOD rating from the CQC I would have no hesitation in recommending TEWV. I think we do provide a high quality service.

I would especially recommend Ceddesfield Ward at Auckland Park for their wonderful service in providing care and compassion not only to patients but to their families.

After care from the Forensic Outreach Service is of good quality compared to other services I have worked with, from personal experience of an ill health family member.

The care is good - problem with resources though it's the only service around anyway.

I believe that adult mental health offer a good service.

All of my experiences with TEWV have demonstrated that they have an excellent approach to the delivery of care to patients and always seek to deliver that care in a compassionate and patient centred way.

This is the best Trust.

Very experienced staff, who go above and beyond their duty to ensure not only patients are supported but families and carers.

Great environment, very friendly staff.

Excellent care/treatment provided by committed, compassionate and caring staff.

I have faith in the services provided by the Trust. The majority of staff in the Trust are positive and want to do a good job/make a difference to the lives of people who use the services. The recent CQC inspection also captured that commitment from staff.

Having recently retired from NHS full time employment I have had nothing but positive experiences of the organisation.

I have found most staff to have the knowledge skills and experience to perform at a high clinical standard.

Because we rock.

Caring staff- talk to people like fellow humans and not 'patients'.

I have a son with Learning disabilities, I would be extremely unhappy if he were to access specific services at Roseberry Park, otherwise I would be happy for any member of my family to be treated in any other service I know.

Have worked in the service and had links with several teams. Found all staff involved to be dedicated to the care of patients and provide good service. Even when service difficulties e.g. staffing levels low have occurred.

Good LD CAMHS service. Good previous survey results from staff and patients.

Loved every min of my job, especially when people’s health is improved- this is clearly the focus of all staff I have worked with in several settings.

We offer a personal centred package of care.

The staff here are committed to helping young people and their families in the best way that they can.

Limited choice as there is no other NHS local provider so would have no other option. Also depends on service as likely to recommend MHSOP but not all services like CAMHS and Adult as have poor experience of these on personal level.

It's the only mental health Trust for this area, what a stupid question.

We are the only Foundation Trust in the North-East to provide specialist mental health care - and people being able to access services based on geography alone is of major importance.

I have been in the position recently of a member of my family needing care from TEWV it was outstanding.

Overall quality of care and treatment is good.

I believe the Trust put their service users first and really care about them. I do wish they cared as much about their carers though.

Patient care is priority and excellent.

I enjoy working within the team, as it is very supportive with people whom work hard with the interest of patient care as our priority.

Care from TEWV and the understanding including needs identified of patients.

I believe that we provide an excellent service.

My father recently passed away, he received outpatient care due to having Alzheimer's. The information we were given by a consultant in Yorkshire he was diagnosed in 2010 proved invaluable, also the support he and the family received from the CPN.

I have a sister and a nephew with a Learning Disability, one with a Mental Health diagnosis also. Both receive community services from TEWV.

LDS services excellent, not entirely happy through personal experience that mental health services have enough resources.

I am confident in the service the area I work in (MHSOP) provides.

I am proud of the service that my team provides and would be confident that my family or friends would be taken care of.

Working alongside colleagues and involvement with other teams I believe all those I have encountered are dedicated and committed to offer the best care and treatment possible and provide effective empathic and timely service.

The staff are caring and well-motivated.

Like any large organisation there are issues. However the people I have met have all been caring and focused.

I have a family member needing mental health care and I'm trying to persuade the rest of the family to agree to look into care with the Trust. Sadly no luck with them yet.

Patients are put at the forefront of their care.

The care and treatment of clients and their carers are excellent.

I think that a high quality of service is available from staff working in the Trust.

The team I work for is friendly, and supportive with a good evidence base and caring attitude.

Excellent care and treatment - putting the patient at the centre of all interventions and decisions - listening and validating the patient and family and carers.

Have helped access for both friends and family.

I think Tewv are a responsive, caring and compassionate service.

Caring staff, excellent environment.

The CQC have confirmed we provide good care - and I know of the progress patients have made.

Very high standard care and treatment.

There is no choice as it is the only mental health Trust around. It also provides good care, but the question is pointless as there is no choice.

Caring staff, good systems and pathways.

Within the teams I work in I would recommend however I have had family treated in MHSOP and I wouldn't recommend it.

Excellent health care and competent experienced staff.

Clinical staff are highly motivated and committed to providing excellent standards of care.

Specialist in mental health and LD.

Because we always try 110% to help the families when they come to CAMHS.

The services provided are excellent from dedicated staff.

Easy access, friendly staff and good communication.

We are a dedicated team and Trust and I believe people get the best care for their mental health.

I have had experience of a close relative being admitted and I had no concerns regarding the quality of care she would receive. I was moved to an alternative ward for the duration of her admission which enabled her to receive the best care and for me to offer support as a relative not a professional.

I would be confident that friends and family would be receiving a professional person-centred approach. I have worked with various teams in TEWV and experience them as conscientious and caring.

Quality of assessment, treatment and care is very high.

TEWV offers a caring, safe and responsive environment.

All staff are very friendly and supportive, my experience with the staff here has been fantastic. The staff here are very approachable which makes it easier for me to approach them if I need help or any support with my job.

Staff are extremely caring and are always looking for ways to improve services for patients.
I feel I would be happy if any member of my family or close friends were ever admitted to this Trust they would be treated with the respect, dignity, and compassion they deserve and would have no hesitation in recommending this Trust.

Yes I would be happy for Tees wards and some community services but not all. I would have concerns about other areas of the Trust.

Staff Experience – Friends and Family Test Quarter 1 2015

Great staff.

I work with some very good staff.

I would be extremely likely to recommend TEWV to friends and family after working for the Trust for many years, seeing what happens behind the scenes. Knowing that nobody is 'just a number', seeing the compassion of my work colleagues and the times they go above and beyond what is necessary. I also believe that the Trust values are not just a 'set of words', they are a belief that they attempt to fulfil. I'm proud to work for TEWV.

Quality of a holistic assessment and treatment package.

We give a good service and provide the best care in our field.

But I would expect long delays in treatment.

I feel that the service is very valuable and makes a difference to a person life.

Courteous staff and nice hospital environment.

I find the values of TEWV to be true and embedded at the top level.

Excellent organisation which is well managed and structured to support service users and their families/friends.

A relative of mine recently had involvement with the Gateway Team in Stockton and the response time was very quick and the intervention they are receiving is fab.

I trust the staff as I know they have had good training.

Care is of excellent quality, high standards, underpinned by robust evidence bases.

Not really any other choice but also think Trust gives very good service on the whole.

TEWV always strives to provide excellent services and there are a number of projects and initiatives underway to improve the 'voice' and experience of people accessing Trust services.

I would recommend friends and family as we provide 100 percent care.

I would have no hesitation contacting the Trust if my family had any needs.

Care, on the whole, is very good and TEWV is the only local NHS provider of mental health/learning disability services.

Response to referrals and I see how people are offered timely, efficient assessment and care planning.

I have a son in services and he receives excellent care from his care co-ordinator.

As my role frequently requires me to review services to patients across the Trust in various locations and service sites. I am pleased to report that on the whole my observations suggest that service provision is either good or in many cases, excellent. Therefore I can quite easily recommend our Trust to family and friends.

Professional and timely service.

Our service is responsive and caring.

Caring, thorough.

Our teams are 1st class and patient care is second to none.

**Likely**

It is the only secondary mental health provider in the area.

With regards to my area of work appointments are timely, staff very caring and dedicated to their job.

Staff work hard to provide a good service despite government and Trust management attempts to make their job increasingly difficult and stressful.

Committed staff who care very much about what they do and how they look after people.

I feel that there continues to be inconsistencies throughout TEWV with the service offered due to lack of resources in areas.

As TEWV are such a large organisation patients can sometimes be transferred to beds outside their local area, making visiting by family difficult. Although I am aware that this is probably something that cannot be changed - it is worth a mention.

I am aware of current waiting lists and their needs might not be met within current target limits.

I am aware that quality of care is affected due to limited resources and staff skills.

If a family member or friend had a physical health difficulty as well it would put me off recommending them.

However dependent on which service they were going to access may affect my decision.

At grass roots level the care is excellent.

The environment and staff are friendly and caring.

There are some issues around out of area care, this is not in any way a positive thing for elderly patients nor their carers.

We are hard-working and there are many specialities however these are unfortunately provided by post code lottery depending on which speciality you require. I have noticed that the Trust are trying to be less specialised in many areas which I feel is a negative approach to care. I would worry if I lived in the right area to access the right treatment. I know of patients who have moved to get the treatment they feel a loved one requires.
The Trust does it best to deliver high quality care in difficult circumstances.

Poor staff levels.

Good support and opportunities to progress in my career. Good staff benefits e.g. Pension scheme and staff saving scheme.

I think some areas are better than others though am impressed with the CQC feedback.

TEWV is an epitome of the modern NHS Foundation Trust, with a fantastic workforce of staff and probably fulfilling all the DoH parameters, but however my concerns stem from the fact that we are increasing relying upon policies and procedures and less on the time tested principles of nursing and medical care which have been given the short shrift in a mad rush to tick boxes, to please bureaucrats, commissioners, Monitor and many other entities in addition to the patients, when in fact the patients have primacy of place in this hierarchy.

Our wards have some fantastic staff delivering excellent care in the face of increasing cuts.

Staff Experience – Friends and Family Test Quarter 1 2015

A friend of mine spent a week in a mental health ward over the Christmas period. He was appalled at some of some staff who ignored patient's requests and appeared to take pleasure in making people wait for meds etc. I am aware that he was not well at the time but when I spoke with him last week he stated that it played on his mind how little help some people were offered whilst they were on the ward. The example he gave was about a man who was on the ward, had been there for two months and nobody had picked anything up from his flat for him or in fact gone to make sure it was secure.

Skilled staff short awaiting times.

Answer would change to extremely likely for some services and locations, others less likely.

The work that they do is great but there is also a lot of waiting times and mistakes, but there isn't many places else to go for support.

I would like to say extremely likely but I think some staff are still entrenched in their ways and do not provide compassionate care.

The service aims to meet the needs of its service users.

Staff are committed to providing a safe high quality service.

I think this is an extremely loaded question. If somebody needed support due to a mental illness then I would recommend that they seek help from Mental Health services in General, not TEWV specifically.

There are certain services that are outstanding such as Stockton CAMHS. They work tirelessly despite limited resources. Also Lakeside Affective Team are very professional and caring. Primary care and Talking Therapies are also working very hard.

Subject to their needs and which part of service they would be accessing.

Staff are caring and dedicated.

There are pockets of excellent practice however I have seen areas of concern (particularly on certain wards within the Trust).

Knowledge of some staff and varying fitness to practice issues that I feel the Trust has decided to 'sweep under the carpet' to a degree. This is however in the minority and 95% of the staff at TEWV are fantastic.

I haven't rated this as extremely likely because of waiting list times.

My relative currently has Dementia, so although she has been discharged back to the GP she may need to go back to the memory clinic once her condition worsens.

It all depends which service and which ward, as I have found in my experience as a carer as well as employee in some cases a different opinion.

The reality is that if people need treatment they need treatment - I would recommend they seek professional support from whatever the local Trust - not in consideration or response to the service as such.

Positive reputation.

Main provider of mental health and learning disabilities services in the area.

Caring, compassionate and experienced staff.

I do believe that staff are generally dedicated and hard working in providing services in often very difficult circumstances, with inadequate resources both personnel and estates.

Staff Experience – Friends and Family Test Quarter 1 2015

I have worked in LD Forensic services for 7 years and have found that the staff are committed empathic individuals who work very hard to deliver the best care possible for their patients.

Some areas are good but staff shortages mean that some aspects of care are not as good as they should be.

I have confidence in the staff that I work with.

Approximately a year ago I was unwell with Mental Health problems and felt that the waiting time to be seen by the service was not acceptable, being 3 months before I even having an appointment. During this time as my health was not improving, I was progressed through the Sickness Absence Policy and came close to having my employment terminated with the Trust. Once I'd been seen and was allocated a therapist I received a brilliant service and I can't speak highly enough of the support I was given and then started to improve once I was getting the correct help.

I would because of lack of other alternatives however I would be concerned about the access they would have to certain interventions delivered by individuals who are adequately trained to deliver this competently.

It depends on the area/ward and staff on the ward.

However, there are some services which I would be extremely unlikely to recommend.

Due to personal experience of visiting family member who was inpatient and there were some concerns regarding elements of care.

Staff are generally very caring.

I would gladly recommend TEWV for care and treatment, however I myself and the majority of my friends and family do not live in the Trust area so it's unlikely that they would receive care from TEWV.

Some patients spend a lot of their time in bed. Often patients explain there's little to keep them occupied.

I feel that sometimes there are long time spells between appointments due to other work commitments and staff change and shortages, which means poor continuity of care.

Sometimes the length of the waiting lists.

It depends on which service and which area.

Sometimes I feel that the quality of care is not consistent and physical health is not picked up.

If anyone needed they services of NHS then I would advise them to see their GP first and if necessary to accept services from TEWV.

I have come across some excellent staff whilst working here, however a member of my family did not have such a good experience, hopefully this was just a one off!

I feel that interaction/relationships between inpatients and community care could be a lot more interactive and the focus of care needs to be much more patient orientated.

Would have said extremely likely if staffing levels were adequate.

Happy with most areas. However, also aware that some areas could do with improvement.

As the cost cutting bites harder staff have less and less patient contact time.

Family members have received high quality care at TEWV

In the part of the Trust I work for, there is a waiting list for clients to be seen which they would need to be aware of.

There are however limited options for services locally which restricts options to TEWV.

We deliver a prompt service, good communication and very good joint working developing a clear plan of care with the service user.

Staff are well motivated to do their very best despite comments below.

Lack of other options.

It would depend of which geographical area they were in. I would recommend local service, but not further afield due to how I as an employee have been treated by colleagues.

Lots of staff do really care.

I am not impressed with the fragmented nature of adult mental health services. In a recent clinic I saw a young man who engaged well and wanted further input but was directed to Talking Changes. This adds an unhelpful barrier to accessing services.

I think the care is second to none by the staff, but the staff really struggle when we have a lot of observation on the ward and the patients who can do their own care don't get any time with the staff as everyone is busy.

This would depend on specific services. TEWV is so vast. I have answered assuming the question relates to my directorate and service therein.

Friendly environment to work with.

I think as individual staff we continue to provide a good service to our clients and within the area I work I have lots of respect for my colleagues, if a family member needed help I would be happy for a colleague to see them, however, with regards to the systems in place to aid access and waiting times due to staff shortages and feedback on treatment I would warn them not to hold their breath.

I know the staff working for this Trust are incredibly caring and thorough however the only reason I didn't give 'extremely likely' is that I am aware many of our teams struggle to provide the care they would really like to due to limited resource (whether that be lack of staff or funding).

The vast expanse of the Trust catchment area makes delivery of care follow a postcode lottery style.

I feel that patient receive better treatment from TEWV and it is very holistic treatment than general hospital care. However I feel that TEWV should improve staffing levels especially on the older persons wards, as these can have very complex patients who have mental health and physical illness which need more time from staff.

The reply to this varies around different areas within the Trust.

'Extremely likely' if living in certain geographical areas but some reservations about other areas therefore average is 'likely'.

It would depend to some extent which service or speciality they would require as I do feel some are better than others.

On the whole the care is compassionate and good.

My granddaughter has been treated by staff from TEWV. We cannot fault the care and help given to both her and her family .

Staff providing service care a great deal but targets and financial pressures take too big a strain on staff stress levels and wellbeing to be able to deliver care to the level staff would like to achieve.

I would recommend treatment however I don't live in TEWV area and neither do most of my friends or family.

Main NHS provider so not many other options.

In comparison with other areas of the country I feel TEWV is patient focussed and risks are well managed.

TEWV is the only mental health and learning disability Trust in the area.

The care in all areas, and I have worked in several is excellent.

Quality services offered.

Depends on the individual and their need and the service needed.

Our services are leaps and bounds ahead of other Trusts in the UK.

**Neither likely nor unlikely**

I work in archives so I cannot really comment on the care aspect.

Poor staffing levels.

I am aware of extremely high caseloads of staff here and a lack of community resources to tap in to.

I believe that TEWV provide poor treatment opportunities to a growing population of individuals with significant personality difficulties which require longer term specialist treatments. I do however believe that staff provide the best care possible within the Trusts constraints and provisions.

It depends on which service they were referred into. Some are very good caring and compassionate, in others the staff are more concerned with their own welfare rather than that of the patient.

There is no other choice of provider in the area, but I would not necessarily recommend TEWV. It would depend what treatment they needed.

I have mixed views. Some staff are great and professional and give a good standard of service, others deliver poor service. I always have in mind when answering this question 'would I be happy for my mum to be looked after here?' The answer is yes with some staff and no with others. The quality of the service delivered is also significantly reduced by the frequent poor/low levels of staff on duty. Martin Barkley needs a significant pay cut, HR staff need to be reduced and management, as does their pay, of which there is significantly unacceptable disparity to the £7.39 I get paid as an health care assistant. Take away the shift enhancements and I may as well work at McDonalds. Keeping health care assistant pay at McDonalds level will only deliver McDonalds quality staff moving forward.

I would not want my family to require our services therefore I feel this question is not appropriate.

Child services are good but stretched. Adult mental health services are quite disjointed and often hard for people to meet criteria.

Some areas have good staff and practice and other are poor.
It depends on what part of the service. For example, some Psychosis Teams and Affective Disorders Teams seem quite sound, but some services concern me greatly, designed to deal with large numbers of

people to hit commissioning requirements, the needs of the patient being (effectively) very secondary to this.

Long waiting lists would put me off recommending the service, as well as some members of staff being rude, abrupt and uncaring.

Staff spend too much time in front of computers and not enough time with service users.

I had a close relative who became a service user of Adult Mental Health Services (both inpatient and community) for a while. I thought the service was slow to respond, lacked cohesion and at no time took into consideration the needs of carers/relatives.

I suppose it would depend what the treatment was for.

TEWV provides a good service between 8 - 4 then it is an extremely limited services. Medical staff particular should be on site on an evening and a weekend.

Financial constraints and box ticking seem higher on the agenda than the good health and happiness of the human beings we are privileged to care for.

Committed staff but not enough of them !!

Do not know enough about services Trust wide- would not want to raise expectations unfairly.

TEWV are the only mental health service provider in the area so why ask this question?

It would depend on which part of TEWV they were referred too.

It would all depend on which service they were accessing and who was care co-ordinating. Some services are providing an excellent service whereas others are diabolical to say the least.

I think staff genuinely care for the individuals they work with but that time dedicated to face to face contact is becoming more and more squashed due to other ever increasing demands on staff and bureaucracy.

They have no choice it’s the only Trust that covers this area, and I think they could do better as I have used then as a family member and also as a member of staff but I would reassure then.

Possibly not, due to very long waiting times for appointments.

I believe the focus of the Trust has shifted too far away from putting the client first. I would worry that my family/friend would miss out on quality intervention because of pressures on staff.

This would depend on the type of care they required and whether any other services were available. Some teams provide better services than others and the range of interventions available varies greatly depending on locality. There is a lack of equity across the service.

It would depend on the type of problem they required help with and whether I had any knowledge of the service offered.
I feel that the service cannot be considered as a whole as it's quality, resourcing, capacity and sensitivity all vary enormously across such a wide geographical area. It would depend on which locality, department and who they were liable to be seeing. This question is far too general and in this respect, the information it achieves will be fairly meaningless. The generality of the question will also result in lots of 'don't know' responses I would have thought.

It may depend on where they live e.g. as to what services are available and what services they may need to access

This would depend on what service.

Family and friends live out of the area. But if they were living in the area then I would be extremely likely to recommend this service for their needs.

There are little or no choices for mental health care in this area, however, as in any other Trust there are pockets of good work and pockets of not so good.

Limited availability of NICE approved treatment, although the reality is there is little alternative options to recommend.

We have a long way to go to meet Trust values, there are a lot of emphasis around this however once out of training staff forget to implement the values. The organisation is very big and intimidating, very hard to police cultures that have built over time. Lots of decisions have been left to the management team, this can cause confusion and is almost a lottery for staff as to who is managing them and how things are dealt with. This then becomes inequality, this then manifests and affects staff moral and behaviour which in-turn effects clients and carers. Let's stop this NOW.

Such a large organisation and the quality of care can vary depending on which services are being accessed.

Some services are better than others and care is patchy across the Trust.

It would depend on which service. Some services have ridiculously long waiting times so I would tell them to avoid referring although the care and treatment would be very good.

The service is by referral only, but since we changed to the 'open referral system' we are getting too many inappropriate referrals for our service, which is causing too much back log and much increased waiting times and a service under great strain.

I am fortunate in that I work for a great team which shields us from the worst of the pressures from above which allows us to aim for standards of excellence. Without that I think it would feel like working in a factory where the service would be moderate. It speaks for itself that TEWV buys in to Toyota's systems to inform how we work. Not enough focus on the fact our client group are human beings, not cars.

Too few resources leading to services being difficult to access, patriarchal approach in some services which seems outdated in modern practice.

Lot of stories recently published/commented with regards to poor treatment and care. It seems to become more and more about targets, spending less money rather than providing the best/most appropriate treatment possible for the patients.

Staff shortages, resource shortages.
Cutbacks in staff numbers are leading to reduced care levels. It depends therefore on what the problem is as to whether or not sufficient treatment will be offered. The care can still be excellent.

It would depend why they were being referred and to what service - this would make a difference to my answer.

It's difficult to say as it depends where a family member may be treated and by which team.

Depends on which service and which member of staff.

No continuity of care.

As I suspect I have said in the past it depends on the team and area and condition the person has. Our services are variable in quality and can vary within each team too.

TEWV is the only provider of mental health services within my local area.

Staff on the front line are committed to providing good patient care - but there is an apparent gap between expectations of higher management and an appreciation of pressures on clinicians.

Likely for Primary Care/IAPT for common mental health problems: Stress/Anxiety/Depression, though an unmet need in primary care for psychology and unable to access through secondary care. There are barriers to patients accessing CMHT support if they have no risk but are too complex for primary care.

Service focus is on paper work rather than clinical care.

We are the only NHS Mental Health Trust available in a large radios.

It is difficult to give a precise answer given that there are limited options for treatment anywhere else, there would be nothing that would persuade me not to advise treatment but it is possible if other options were available that they would be used in some circumstances.

TEWV is a very large Trust covering a huge geographical area and therefore without having to travel miles for treatment it is likely that family/friends would receive their treatment here. From a confidentiality point of view it would not be ideal for family/friends to be treated here.

This would depend on which services friends and family would require as I don't know how all the services.

Some of the care provided is excellent, with fantastic members of staff. However, waiting times are extremely long, both for referral to services as well as actual waiting times when at appointments. This can be particularly bad for Crisis Team which obviously due to the nature of the service is even more crucial than others.

Waiting lists are more important than appropriate treatment.

**Unlikely**

Poor support and feel undervalued by manager.

Trust is too risk averse, to centred on meaningless paper exercises to count pointless statistics which supposedly highlight patient care, but in reality do little to improve the quality of care people experience but can be a burden to staff and remove staff time away from patients.

They're not covered by the Trust's geographical patch. If they were I would be extremely likely to recommend.

Though care is first class learning disability units are too small and noisy.

Have had previous bad experience with family members trying to obtain appropriate treatment.

Wards are very often short staffed and the staff they have are unable to take a break during a 12 hour shift. This leads to low staff morale. Also because of this patients are not always able to take their allocated leave from the ward if staff are require to accompany them.

It takes too long to see a consultant.

CAMHS services are extremely stretched at present, making it very difficult to provide a timely service.

We have gone too big. Staff morale is extremely low.

I can judge only from the team I work for and currently this team seems to be very disorganised with some considerable needs with regard to resources, leadership and systems in place. The computer records system is unwieldy and does not lend itself to usability and usefulness. Much time is wasted and duplicated in using this system.

Under resourced services creating gaps in care.

They will have to wait for therapy , they are likely to be treated by a member of staff who has a high caseload and is doing the best they can to squeeze more appointments in when they should have time for people and thinking time and supervision time.

Trust strengths - quality of care and compassion. Areas for improvement - very limited resources/funding and depth of services in comparison to Trusts down South.

Wards understaffed, community teams all overworked.

The quality of care has deteriorated due to the immense pressure to complete documentation which has drastically reduced the time available to spend with patients. The recent changes to teams has meant that the geographical area covered has tripled in size- this has resulted in a dramatic increase in time spent driving to appointments which further reduces patient contact.

Within the area that I am employed I don't think the services are patient orientated and services organised to suit services.

I do not feel that clients get the first class service they need due to the many cuts and shortages in staffing levels.

Very poor change management, poor regard for professional values, skills and experiences, a misplaced belief that standard processes and procedures can replace all human decision making. Insufficiently responsive and individualised clinical care. Misplaced emphasis upon diagnostic categorisation rather than client centred care and experience.

I have family circumstances that have involved using CAMHS service and being on the other side isn't a great experience in my case.

Due to reduced staffing and increased pressures on the staff team in regard to demands, I would not recommend people to access TEWV as they would experience waiting times and less of a service than they deserve.

It would depend which service they were referred to. There are some very good services and staff but unfortunately the standard of service provision is not consistent across the organisation.

TEWV doesn't consistently put the patient first and foremost, e.g. sometimes prioritising meeting attendance by staff over direct patient care.

Trust is geographically too large, and I would advise relatives/friends who live in my locality to cross the border to the North to get all the treatment they will need from one hospital instead of travelling between 12 miles (nearest hospital) and 45 miles (furthest hospital regularly used).

Fragmentation of services and poor quality of clinical work.

**Extremely unlikely**

Disjointed under-resource, inefficient services.

A particular service I am aware of is run by a bully, focus is on targets not care, staff are leaving and the ones of us left are having to do more and more.

Lack of continuity in care and also time restricted in contact.

Not as if people have any choice over the provider of mental health services.

Because they only treat the acute problem and offers no holistic support for people in North Yorkshire to

provide psychotherapy over a long period while they are an in-patient to visit their traumas which led them to their acute psychotic state of mind. Therefore they never recover and become recurrent inpatients to the acute ward. There is no support for them as parents and no recovery program is offered. They do not engage with the family.

I have witnessed very poor care on one of the inpatient wards.

On paper the Trust is good - the reality is that there has been a massive decline in actual, compassionate, person centred care. Patient care has become a tick box exercise and patients themselves are nothing more than a cluster number. Clinician's now spend so much time on evidencing patient care, that patients are hardly seen unless in crisis except to hand them a bit of paper or a survey.

The Trust has mixed values and messages. It is keen to tell us and teach us about values for the patient (which is, indeed, of the utmost importance) but the implementation of basic stuff in order to work as a therapist falls woefully short of this sense of values that it seems to hold so proud. An example would be that our offices and clinic rooms are not sound proofed and my confidential sessions with patients can be heard by the reception staff (who are not TEWV employers) and employers from the other organisations that rent offices in the same area. Confidentiality is compromised for the patient. Which value does this tick??

Poor service due to excessively high workloads and lack of support to staff concerns.

The Trust does not put patient's needs first, it is all about money and business. There are some excellent clinical staff within this Trust, who work incredibly hard under difficult circumstances to try to do the best for patients, but targets and PARIS get in the way of patients.

This question has been asked time and time again and my answer is the same as the last time. It doesn't matter! The Trust is so geographically large that there is ultimately no other Mental Health Care provider available therefore this a moot (and supercilious point). Hypothetically if there was a choice I would be reluctant to recommend the service as I feel that the Trust is led by financial motives and that care quality is not the prime concern of the organisation. Rather it is the balancing of the books.

This is not a patient friendly service.

I see how staff are too stressed with work well beyond their normal capacity levels, which leaves them unable to offer the service which patients deserve; I have a real empathy with the staff, as it is not their fault, but negative management.

Lack of support, negative feedback is constant.

I have a friend/ colleague who has mental health problems, she works for TEWV NHS. She has seen a psychiatrist who recommended CBT- she has been trying to get this through TEVW but out of her home area- due to working as a mental health nurse! This has now gone on for over a year- still no out of area service will take her, she is still experiencing mental health issues and is at work. However has received no support through work!!!!!!

Provision for adult mental health problems is very poor.

Too long to get an appointment, if you get an appointment at all, services dispute where your care will most appropriately lie and often advised to seek support from outside the Trust after wasting time waiting for that decision to be made. Other services are more accepting of referrals and more proactive in making you feel like your needs are being met.

Clinical staff very good but ability to offer care eroded by Trust management and culture.

**Don't know**

I don't work on the wards so cannot comment.

I have no experience of being treated by the Trust.

Cannot answer this as I do not work on the wards.

I have very little contact with wards or staff so cannot comment on the care or treatments they provide so therefore cannot provide an accurate answer.

I do not work in a clinical area, so I do not see the care that patients receive.

I don't think my friends and family would have a choice and knowing some of the staff I think client experience is very much dependent on their expectation and how the staff they are allocated to match that expectation.

It would depend on the type of service required and the location of the service being accessed.

**How likely are you to recommend this organisation to friends and family as a place to work?**

**Extremely likely**

Because up to now I have found the management organisation good.

As an employer I find TEWV extremely supportive and feel it is a place I would like to spend the rest of my career working for.

Because I have found it to be a great place to work. I have been here for almost 18 months and have found the Trust's culture to be committed to supporting and developing staff which has been extremely refreshing having come from an acute medical trust.

In my experience the service offers its workforce a good level of support and training.

There is a good culture here of learning and tuition - the workplace is fair, is supportive, and often gives people the chance to resolve issues rather than ignore them.

I really enjoy my job, the people are helpful and always willing to explain new ideas, as bank staff this is very important.

We are very well looked after by the Trust in terms of provision of wellbeing programmes, mindfulness, family friendly policies etc.

Good induction and training for new staff as well as good support for staff from senior managers.

The Trust is very fair and supportive of staff and offer great training opportunities.

Great place, nice people.

I have already spoke to friends who are looking for employment, and have used my own experience of how supported and helpful everyone is.

Supervisors are great and very flexible with employees on holidays and the likes.

TEWV provides staff with excellent training and career progression opportunities.

It is a good organisation to work for and I love the positive energy in the organisation.

I have always been treated fairly as an employee. My past and present managers have always been supportive to me.

Staff Experience – Friends and Family Test Quarter 1 2015

Having worked for several local Trusts this is by far the best place to work.

This is a great Organisation to work for. The people are supportive, hardworking and there is always an opportunity to develop.

TEWV is a great employer. Supporting the development of staff.

Flexible working practices and feel valued.

I feel I can influence decisions and suggest improvements. The Trust provides good training and development opportunities.

Very supportive staff- consultants, nurses etc. Everybody is eager to teach.

Friendly, engaged staff. Variety of work. Clear direction of the Trust plus Staff Compact.

Supportive and close team.

Proud to be working for such a reputable organisation.

Compared to other NHS organisations that is.

I feel I am a valued member of the Trust, well informed and kept up to date.

Lots of opportunity for development.

The amount of support from managers for personal development through completion of courses is amazing.

My experience has shown that TEWV is an excellent place to work where the organisation devotes a lot of time and resource into staff development, staff wellbeing and staff engagement.

The Trust is very supportive of their employees.

Good working conditions and management compared to other local mental health trusts.

I have found it an excellent Trust to work and train for. I find staff in all settings helpful and proficient.

Well led, opportunities to learn and develop.

Excellent Trust to work for.

Already have two of my family working for the Trust.

As above. However the ever changing challenges facing nurses- from private initiatives - impact upon Staff morale.

Structured supervision and appraisal processes that allow for and acknowledge development potential and opportunities. Trust promotes a can do motivated attitude to staff to encourage development which in turn results in improved patient/carer outcomes and service provision.

Staff are friendly and welcoming.

Only commenced in post 2 months ago and I am delighted with the choice I took to work for TEWV.

CPD and support excellent.

TEWV is well led. Staff training opportunities are given high priority.

Excellent facility with a fantastic team working together.

Feel well supported, the Trust looks after it staff.

There is a vast amount of experience to be gained within the Trust, especially for people at trainee level.

Friendly staff and management is well lead, especially training and development of staff.

Good support and opportunities available to all staff.

TEWV takes pride in looking after staff and patients.

I have already recommended my friend to work with us at my place of work.

I am very happy with my job.

Have enjoyed working within the TEWV environment since starting here.

Lots of opportunities, good management.

Having worked for other Trusts, TEWV is the only one I would recommend. Engagement between senior management and the 'coalface' workforce is strong and there is a two way dialogue. Success is rewarded here (as well as picking up on challenges/negative events), whereas in other Trusts only negatives are commented on.

I feel my voice is listened to.

Only recently returned to Trust, pleased to be back.

I have worked for the Trust in its many guises since 1979 and have seen the organisation grow from a small local service into the wide ranging provider of services it is today. Many of my family and friends work for the Trust already and have done so for many years. I have been fortunate enough to have been supported by my managers to explore and develop my career throughout my employment and would highly recommend the Trust to anyone as a great place to work.

My employment experience has been very positive.

My daughter is currently carrying out her nurse training with the Trust.

I was moved to the main hospital 8 months ago. I have benefited from the support provided by my new managers, I feel I have been listened to and any issues concerns have been dealt with quickly and fairly. I have learnt a lot in a supportive, nurturing environment.

I have found the organisation supportive, with good structures in place.

The culture at TEWV makes me feel very valued as a staff member. Other staff are helpful to me as a fairly new starter.

I have worked for the Trust for a number of years and find it an excellent employer with great opportunities for career development.

I myself have worked here for a long time and I enjoy my role and get lots of job satisfaction.

Basically my mother, father and sister work for the Trust and I have done so since 1998. So this alone is why I would rate it so high. We are all registered Mental Health Nurses and between the four of us must have more than 70 years trust experience.

I am proud to work for the Trust and have a great manager and team. Always feel listened too, and am able to offer suggestion for change/improvement and play a part in team decisions.

Teams are very friendly, excellent policies in place.

Good team working, superb team leaders, well supported.

The Trust offers fantastic opportunities for career development and working for the Trust is rewarding; the face to face feedback from clients makes the job worthwhile.

The culture has completely changed in the last 7 years and now transparent and engages with staff well and much more supportive than in the past.

It's a lovely environment with great colleagues.

Good management and opportunities to develop self.

I have recommended TEWV to family members and friends - some of which have since been employed by TEWV.

Working environment gives good support and opportunities for progression and training.

Very focussed on improvements and team cohesiveness and headed up by a very strong Chief Executive. The fact that the Trust are also so committed in the development and wellbeing of staff ensures the TEWV culture is strong and a place you really want to work.

Great management.

Good place to work, good support systems in place.

Team effort, good communication, caring staff and great leadership.

Nice place to work

Because we are always here for our families.

Lots of training and support/supervision. Invest in the staff, lots of opportunities. (Think staff safety in the community is better at other Trusts though).

**Likely**

I think TEWV is a good employer, but again I expect it depends on which part of the organisation you work for.

Good staff support and benefits.

Culture of favouring certain staff persists in most areas.

I have had a positive experience of the Trust thus far and feel that the service has evolved and is continuing to progress. However at times as a practitioner working in an emotive field I have felt unsupported.

I would prefer to not have friends or family work with me but I would tell them about posts in other areas of the Trust.

There seems to be excellent training and peer support. The opportunities to express concerns and for these to be responded to are reasonably good too and better than a previous Trust I worked in.

Staff Experience – Friends and Family Test Quarter 1 2015

Overall I feel that the Trust is a good organisation to work for - however it can feel very pressured at times which can impact on morale of staff.

I love working for the NHS but I do feel that the NHS in general is not all it could be as an employer - the job security is good but the pressures are intense.

I thoroughly enjoy my job as I work on different wards so would recommend this to others, however I would not recommend a permanent job as working on a high pressure, stressful ward full time could lead to burn-out.

TEWV are good employers.

Good local and senior management support, lots of opportunity for development of skills.

I work in a lovely supportive team. Money will never be an incentive so would also be suggesting to friend they strongly consider private sector.

It is a relatively good place to work for however if you are unwell I feel they try to pressure you or threaten ending employment if you can give a specific time of coming back. Also problems with wages.

Even though the work is challenging it is varied and interesting and staff are supported through supervision and training.

Terms and conditions of service are much better than in the private healthcare sector.

NHS framework provides structured working environment, however, delays in replacing staff who vacate posts causes stress to staff already working at capacity.

Opportunities for development/ongoing development.

Although work pressures are always evident to a degree I feel staff are supported with aspects of both professional and personal aspects.

I have heard of how other NHS Trusts treat staff members (HR etc) and how things get swept under the carpet, but I have worked for this Trust over 4 years and find it to be transparent in the way it handles things (in a good way).

I would recommend only certain areas of the Trust to work in.

I have worked for TEWV for approx. 12 years I have had some good times and some bad times but throughout I have received fair treatment.

Biggest issue is the geographic spread of the Trust.

Good Trust staff values positive employer.

TEWV are a good employer but you have to be prepared to work over and above your contracted hours to keep up to date with your workload. This is the only way to meet the high standards and not breach deadlines.

Again it seems to become more and more about targets and budget cuts resulting in more work load for less staff within a team. TEWV use to be a place where jobs were secure and the best place to work for, for a life career however with budget cuts happening more and more staff are being made redundant.

Some people who are hard workers do not feel valued in their work from Management.
The Trust could be a great place to work. Sadly, leadership within the organisation has become a victim of endless and pointless so-called quality improvement events. Soon we will need a quality improvement event about how to buy paper clips. Staff are losing what it takes to be effective and relevant

clinicians...while they wait for RPIWs to tell them.

It's a lovely, supportive team but there are huge capacity issues and pressure on staff, meaning decent nursing work is almost impossible.

Although workloads and caseloads can be demanding, most colleagues I come across in the organisation are committed and caring people. TEWV feels a relatively secure place to work in the current social context, and there are good development opportunities compared to what I hear about working in other Trusts.

Can be very rewarding.

Again, there are issues that often go unchecked but overall I think it is a very forward thinking Trust and service who have the right goals and values.

Great staff to work with.

I have worked for a number of Trusts and I would say that TEWV rates highly amongst them.

No-where is perfect, but TEWV is a very professional organisation. I think much better for younger people to work in.

The job is brilliant but so much can depend on management, political pressures etc.

Although likely I would say that TEWV is a stressful place to work.

It is a good employer but I think working conditions in the NHS are declining and set to get a lot worse.

TEWV great so far! However, there is one work place I would not recommend due to a bully being in charge! I now take greater care and research the work place more than I may have done previously.

Pleasant working atmosphere and supportive teams.

It's a more stable NHS Trust than many others with good leadership from the top. In the main employees are looked after and supported.

I have increased awareness of TEWV's procedure relating to the redeployment of staff on medical grounds, which has left me shocked and exasperated. TEWV has signed up to the jobcentre plus two ticks, a working document regarding the non-discrimination of staff with disabilities. This cites redeployment, amongst others, as a reasonable adjustment. Redeployment for staff with disabilities, within TEWV means that staff who need temporary or permanent redeployment could have their contract terminated after a minimum of 4 weeks. How can this be non-discriminatory?

TEWV is a supportive employer.

Again, some departments/areas good to work in other are not so good.

It's a good place to work, feel well supported and there are opportunities for development.

There is an obvious discrepancy in the messages that originate from senior level management and middle level management, making work life a bit confusing.

I work in a team which I love - this may differ in other areas.

A couple of years ago, I'd have chosen the extremely likely option, but have downgraded this to 'likely' because the organisation seems to care less about clinicians than managers. And managers appear to be operating with impunity.

I think the negative things such as changes to pensions and cuts etc are global issues and the Trust has dealt with them as best they can.

Better than where I used to work and where most of my health care friends still work.

Although generally TEWV is a good place to work, some supervisors and managers do not have the necessary people skills to manage staff. I speak from experience because myself and my colleagues unfortunately had to lodge a grievance against our supervisor who stopped us from using staff rest facilities at all sites. He was backed in part by our managers with no explanation. Eventually HR found in our favour and re-instated our right to use all staff facilities. I feel that if supervisors and managers had to go on a people management course then this situation would never have occurred.

Our current management has provided a great improvement in staff morale.

As a clinician I feel I have clear guidance in my role. I am well supported and have appropriate training.

I would recommend TEWV as a good place to work, good working conditions, friendly colleagues, pension, flexible working hours.

I have recommended friends and family to work at the service.

Opportunities for progression.

Depends on the person, their skills and experience and role that they are considering.

As we have become more efficient, we have also been less caring towards staff. Less emphasis in put on emotional and morale support to staff.

However, there are some work places/services which I would be extremely unlikely to recommend.

Value stream mapping impractically tight on time allocated to duties. Wage OK. Extra hours likely but only up to 37.5 hours. Free parking at your own risk. Uniformed staff well supplied.

**Neither likely nor unlikely**

Stressors within workplace are significant due to CRES savings reducing staff team members, both clinical and admin.

Very stressful.

There is a lot of pressure of work these days on teams and so would not wish to influence anyone's decision.

Somewhere on the journey between board and clinicians there seems to be a lack of respect developing for professional opinion.

Depends on their skill set.

Staff shortages on all wards and nothing ever seems to get done. Having to spend over the Trust guidelines of two hours on observations. Nowhere to take your break or a designated room on some wards to eat.

While there are a lot of positives to working for TEWV, there are several negative points.

Low staffing levels and high demand means that morale is quite low.
It would depend on the position they would be undertaking and the area which they would be based.

Depends very much on which directorate/service.

Whilst the organisation does seem to try to involve staff the increasing bureaucracy and layers of governance and management seem to leave staff feeling out of touch with what is going on.

No other choice within mental health within the area now. There are positives to working for TEWV but also negatives but either way there is no other choice.

It's very 'task' focused as an organisation and not very people focused. Too many policies exist. Standards are important however policies make it difficult for staff to give the individual client centred care that's needed. Some managers are a pleasure to work with however some are more interested in all of the boxes being ticked rather than staff fulfilling their potential and ensuring excellent patient care.

I am not sure I would recommend the NHS at the moment as an ideal place to work. I suspect TEWV is no more challenging than other NHS Trusts and does have some positive aspects.

Again despite having a recruitment and retention of staff policy I have watched newly qualified staff quickly become overwhelmed and disheartened by their role/job within the Trust.

Some of the rules are too black and white, plus some people get away with far more than others, people are not treated fairly which causes frustration and disgruntled feelings amongst staff. Circumstances are not always taken into account when being disciplined and not everything is that clearly defined, background circumstances can change how we react and what action we may have had to take yet this isn't taken into account. If a rule says this then that seems to be the law, there's no give and take. Plus the sickness rules are too rigid. Some people don't appear to be monitored for their time off yet others are watched like a hawk, totally unfair treatment.

I live in hope that the care will be person centred and not financially driven. Currently, there is a lack of services, which means that there is no help or support for the mentally ill in Scarborough or North Yorkshire. There is also no Early Intervention Services in Scarborough or North Yorkshire.

Working for the NHS as a whole (not TEWV) has its issues, as all company's but if you want my job role you work for the NHS, this means that when you want to change jobs as the conditions are becoming intolerable you cant. The intolerable is the need to meet targets at the behest of anything else, not caring how much unpaid work and stress is needed to get it done as long as you don’t upset the target and stop the TRUST getting paid!!! TARGETS again, last question are you a smoker, I suppose it stops you asking what church I go to and whether or not I am Gay. Again I know this comes from the Government not necessarily my employers.

In the past I would have chosen likely or extremely likely but due to recent changes (previous place of work closed and current place having been informed of TUPE) I now feel that there is little security within TEWV Trust.

Currently I feel we work in a fairly highly pressured environment. Workloads and caseloads are too high. Pay freezes and pension changes don't make me feel rewarded or appreciated. I feel our pay rises should be in line with private sector. 1% in however many years is a slap in the face. Public sector workers seem to pay the price for cuts. Pension age is getting older. Where is the incentive to friends and family? I am passionate about what I do and take pride in my work, unfortunately I do not feel rewarded financially for it. So much so that I am considering looking to work elsewhere so I can provide more for my family.

Again it would depend on which service they were looking to work with.

I have had a mixed experience in the Trust from a staff point of view but have always been happy with the support I have received, just not always with the outcome.

I think that the work with clients must be one of the best jobs ever, however the Trusts focus on NHS market structures (meaningless targets) coupled with a lack of real leadership and head in the sand approach to change, make the organisation frustrating at times.

Due to resource - my colleagues are regularly working more than their allocated hours - resources are tight.

Also, I do think staff should be treated in our locality a little more as intelligent individuals with their own ideas and concerns, and should be dictated to a little less. Some of the tasks set are additional to requirement, unnecessary and increase the burden of the workload -at times tasks/changes set by management can be regarded as fads in that they say something is crucial, and a few weeks later they require that staff don't engage in them anymore.

I love working here however we are short of staff due to financial restraints and it is obvious to see the strain that demand has put onto the service/staff and therefore staff are often carrying large caseloads which grows more and more so becomes very stressful for all concerned.

If someone I know is prepared to work hard, do above and beyond their role and job, work extra hours without pay and do not require a great deal of support in the workplace then I would recommend TEWV NHS as a place to work.

The team is overwhelmed with referrals at present and there is staff burnout within the affective team.

Staff spend too much time in front of computers and not enough time with service users.

The patients care is impacted on by the paper work, staff unable to provide the appropriate levels of care - less input to where it needs to be which is to nurse poorly people. Environmentally door slam the noise levels are very high. Staffing levels can be poor at times on the wards. However staff on the units do attempt to rectify this within their capacity. The area I currently work in is safe, supported by management and we the staff love coming to work. The 136 crisis assessment suite is proving to be a very much needed service.

Lack of rest breaks and too many 12 hour shift on a row.

I am aware of people who work for the Trust who are very unhappy, often on sick-leave with stress-related problems. I am also aware of people who appear happy in their work. Again it would depend on where and in what capacity they were hoping to work in.

Can be a good place to work and can provide many opportunities for development, though many staff experience stress/depression not through clinical work but through poor management.

I find some areas of the Trust are not as supportive as my own experiences. This may be because of the area I work in or possibly the resilience I have developed over the many years working for the Trust. There appears to be a culture of blame and target driven objectives that inhibit staffs ability to do what they do best and care for clients.

It would depend on what department they choose to work in as the managing and treatment of staff varies hugely within services/departments/wards. I definitely know where I would recommend they don't work!

I believe working conditions, staff shortages, inadequate estates, performance management and staff welfare have all deteriorated over last 3-4 years.

Depends on the area you work into. Patches of excellent working and supportive environments, however this is still patchy.

Whilst TEWV is a good employer the NHS in general is no longer an attractive place to work - financial constraints - pressure on front line clinical staff - money before patients etc.

I feel that due to additional duties it is difficult at times to keep up with work load as a care coordinator, for example single point of access and assessment clinic. I feel that given we are constantly reminded of Trust performance it would be more beneficial in the long run to have the additional duties covered by dedicated staff which would enable continuity and would leave care coordinators to keep up with performance targets.

The very same reasons outlined above make TEWV less of an attractive place to work particularly for those genuinely interested in doing the best for the patients.

Because although I have worked and studied hard, I have not been fortunate enough to have had a career in the Trust - I have had a job. But opportunities clearly are there for some people, hence the neither likely or unlikely answer.

I don't drive and most the training is at Flatts lane so my husband has to take me and take a day off his work, as I was told off my manager training is my responsibility so I have to get there. It's better if I can go with someone who drives but that's not always the case. So it's very hard when not a car driver.

Depends on the service.

Used to think that an NHS job was a job for life but not anymore. Policy changes without consultation and harassment when off legitimately on sick leave - made to feel like a criminal.

Whilst the Trust overall is largely good to work for, within the Yorkshire area services can feel neglected and not part of the Trust as a whole. Therefore I would recommend them as much as any other employer.

Worn down by the bureaucracy and lack of higher management support although this is by no means specific to TEWV.

Since the Trust has become a Foundation Trust, I understand that it's a business, it feels as though targets are prioritised and not the service users or staff.

TEWV is one of the better NHS Trust Foundation organisations to work for but I would no longer recommend that any of my friends and family should work for the NHS.

Once again it depends as some managers are supportive and some are not. Managers say they will support you but they don't always.

If roles were as they should be and work was as it could be then it would be a better place to work and I would then recommend it to friends and family.

Staff strain due to staff and resource shortages. Stressed staff.

Possibly but pay is too low for such a stressful job and there is no hope for a pay rise.

Pro: the organisation is well managed, with good support and incentives for staff to develop their range of skills. Con: Uncertain future given the commitment of this government to impose weak ideological havoc on the NHS.
I would say it depends on the team.

Depends on which service they would be working in.

I had been very positive about our Trust in the past, having trained in the Trust as well, however over the past few years, I have realised that it is who you know or are close to is what matters for your viewpoint to be considered and not the hard-work and sincerity with which you have worked and are still working.

This would depend upon which area they were wishing to work in.

I feel quite a lot of pressure filtering down, which increases anxiety even when you work hard. However, CPD is excellent.

Working environment has been extremely stressful over the past few years.

I enjoy my job but it is very intense. I am not sure I would want my daughters to have the same amount of pressure in their work life. However I feel TEWV are a good employer.

I feel very ambivalent about the Trust at present, suspect it is no better/worse than other NHS Trusts.

I would leave the decision up to them - there is bullying inside this Trust - I am a victim of it and I have been here for 10 months on a fixed term contract. Whilst my manager is very supportive and does all she can within the limits of her post, the people responsible take no notice and continue acting in the way they do - this has happened to three other members of staff (two before I started working here). As a consequence, I would neither recommend nor try to prevent someone from considering to work here - that decision would need to be theirs.

At the moment we are understaffed and overworked.

I wouldn't want to recommend someone else to come along and be in the same position as I feel I am in at times.

It's a stressful job.

I wouldn't recommend working for the bank at Roseberry Park, management are unapproachable and rude and my pay has never been right.

The answer is similar to the last. If you work in a place that is well organised then things are pretty decent for the public sector. However if the service you are in is struggling then you are unlikely to enjoy your time at work.

**Unlikely**

I am disillusioned with the NHS in general.

As commented above and I feel the majority of staff work really hard but are not appreciated for this work instead they are blamed when anything goes wrong.

My caseload is double the recommendations by NICE guidelines and I regularly work over to get paperwork done.

For the past 17 years I have worked for the Trust on the whole I have been very happy to work for TEWV however the past year I have been in a post that was initially coming out of a pilot phase with year on year funding. I was told that once out of the pilot phase the funding would be secured. Here I am a year on facing further uncertainty with my post without guarantees from managers. We are a team of 4 and we are being drip fed different information. Unions are now involved.

The HCA pay is absolutely disgusting, and does not reflect the high quality work of those like myself on the front line. We need minimum numbers of staff. The unit is not safe for either staff or patients.

I have a member of my family who has chronic and enduring mental health problems. He lives in another part of the country and the services he receives are simply not available in my locality - ongoing support in finding employment which is a major form of support, long term and ongoing input from the Community Mental Health Team without feeling a pressure to be discharged.

Too much focus on paper work which impacts on patient care.

I wouldn't recommend the Team I currently work with as there is always tension between certain members of staff which results in an uneasy atmosphere.

Again it depends upon what part of the service, e.g. Lakeside ADT seems a great place to work and no-one wants to leave, but presently I wouldn't recommend my own team as it is in special measures and with difficult team dynamics.

Departmental financial constraints results in staff being thinly spread which affects personal strain, opportunity to progress and morale.

Sadly care coordinators on the ground in the community are woefully under-resourced with unmanageable pressures and expectations particularly around paperwork/targets. The Trust is also not supportive of staff regarding positive risk management and a blame culture remains, with very unsatisfactory procedures following serious incidents. It is impossible for staff to work properly with community patients due to these pressures, and makes working for TEWV a disappointing and unhealthily-stressful experience. Whilst the Trust implements very good initiatives like Mindfulness Training for staff, it fails to address core problems which create the stress in the first place. I would not recommend anyone work for TEWV, although I accept the situation may be no better elsewhere in the NHS.

Poor management - treated as a business.

I wouldn't recommend TEWV as a place to work because I feel the Trust offers/promises much in its corporate literature/advertising, but actually delivers little. There is a 'tick box' mentality in this Trust - although I acknowledge this is most likely to be NHS - wide, not specific to this Trust.

Understaffed and negativity from the Board to those working on the wards.

Unlikely, if they want to progress their career based upon their commitment as progression is limited/blocked if one is not in the right clique; regardless of the policies only certain individuals are selected.

NHS pay and conditions continue to deteriorate.

Don't believe some of the teams treat people with respect.

I wouldn't want my family or friends to work under the pressure associated with an AQP service and the scrutiny this comes under.

My reason is a personal one, but I do not think that the Trust deals with bullying and harassment as it says they do in the policy.

Feel undervalued, not by the team itself, by the Trust.

The process of service delivery has become increasingly bureaucratic and time consuming . Clinical staff are rarely thanked and despite a 'Good' CQC rating are often criticised for being unproductive whilst the Managers add a steady stream of new processes , which almost always complicate the system and take time away from delivering face to face patient care.

Ineffective leadership, poor morale, unrealistic expectations. On a more positive note training is very good.

I feel that in some areas of nursing e.g. organic wards the 12 hour shifts are too long. These shifts are extremely busy and stressful from start to end I am starting to feel burnt out.

In my experience the values and behaviours of the Trust are not always demonstrated by those in very senior positions but are demanded of those in more junior positions.

Poor support and feel undervalued by manager.

I think demands and expectations of staff are excessive and stressful.

Again staff morale is extremely low. You have to do this training and that training so not enough time to concentrate on your job. I am a medical secretary and have worked here when we were Durham Area Health Authority. I am up for changes but managers seem to want to mend things that are not broken!!

The Trust will give the impression that it looks after its staff but in reality staff are just a number and the number of years dedication given means nothing.

Staff provided a great service but do so at a detriment to their own mental health, as procedures and

targets make things very challenging.

Pressure on clinical staff is huge feels like there is no investment in LD services in NY Clinical staff are duplicating on work. Demands from corporate staff are huge and timescales minimal which is difficult to achieve when under pressure for clinical work. Organisation is massive and messages are lost, sometimes feel risky. Higher management and Board need to be doing work on the ground to see pressures. Computer system is not fit for practice and does not support the clinical staff. Real focus on mental health that it feels like LD is a second thought.

If staff get injured at work, the Trust should at least take care of them, if not at least not accuse them. Otherwise it's a great trust to work for.

Pay is poor. Pay freeze for years (pay cut in real terms). Particularly unfair for trainee band 3 who get paid less than band 2. This is ridiculously unfair. Also, overtime should be paid as such not as bank. We have an overworked workforce and they should be paid accordingly. Also the pension scheme which is being depleted year on year. Not only for new starters but those already on the pension scheme. I pay a lot into my pension but have no confidence that I will receive a good pension when I retire.

It is now a business first rather than patient care. I understand this is the same everywhere and not just this Trust but it is very difficult to be able to carry out the things you need to do now and this makes working in this environment demoralising so therefore I would not recommend working in the NHS to friends or family.

The staff are not cared for and treated equally by the board, (e.g. CEO gets massive pay rise and we all get nothing).

Poor recruitment process, extremely poor staff retention with several staff leaving for neighbouring Trust, staff often feel undervalued and frustrated with the way services are ran.

Having been a committed, loyal, enthusiastic and business orientated staff member, I have become increasingly demotivated that the Trust does actually truly subscribe to the values/compact and behaviours they portray as their logo.

I have friends in other Trusts who are finding it even more challenging than staff here and I am aware that in my area there has been no redundancies or re banding but the freeze on posts and the staff turnover is causing difficulties as well as numerous new systems, ways of working and protocols for auditing that add too much pressure. I would advise family and friends to think carefully before accepting a job within the NHS with any Trust at the present time but if they did, to look to TEWV first.

Not enough support for staff, management are not interested in family friendly off duty and now want qualified to work a 12.5 hour night duty and remain with the keys during their unpaid hour break, meaning that the qualified are effectively on-call and cannot sleep or leave the ward during this time and get no pay for this, if unable to take a break not paid overtime rates.

Fail very badly as friendly employers, do not seem interested in individual workers more about making money.

Likelihood of being forced to work for private company, imminent privatisation of services.

Teams are supportive and promote a positive place to work however higher management have poor view of case load pressures and safe staffing levels often leaving teams to struggle and absorb caseloads and not putting out posts in a timely manner.

I have experienced I felt mistreatment which as a result lost my home after a patient complaint. I was unable to work extra duties which I relied upon for my mortgage. The whole experience impacted on my mental health and after 5 months of investigation to be found nothing to answer to makes it extremely difficult to recommend TEWV as an employer.

Don't like the top down macho micro management style.

Lack of support from management and a totally unfriendly place to work.

The lack of staff and shortage of IT equipment makes completing a task difficult.

**Extremely unlikely**

Work load too high, general expectations and targets unachievable in the time available, end up doing a lot of work in own time causing personal and family stress.

Trust management are so far removed from reality that they have no concept regarding the pressures placed upon front line staff and lower management, working practices are unsafe and set to implode.

I have been off work with work related stress, owing to three full-time Admin Secretaries being short out of what were eight before we moved. I have voiced my complaints since the first month of being in the new building, and have continued to do so via Admin Minutes. The remainder of our Team are voicing the same, and two full-time Admin staff walked out of their job in tears, and didn't put in any notice. They have not returned, and our situation is seriously under-managed, using the excuse there is no funding to replace staff.

Lack of memory or loyalty within management.

Care co-ordination is now an impossible job to do. The impact of my job on my family life has been extremely negative over the past 18 months since changes to the team has taken place. Most of my colleagues with many years of experience have left.

The whole job has become so stressful and no enjoyment with coming to work anymore. Not appreciated.

Nursing staff are currently being employed as Trainee Health Care Assistants and are barely making a liveable wage. Being paid a lot less than domestic staff who’s job does not involve the risk of a HCA in this service.

My husband works for TEWV and the patients he works with are being moved out of hospital to a private provider, he has to accompany the patient and lose his job in TEWV/NHS and be employed by the private provider, no warning has been given, he has not been given a choice in the matter, if he refuses he loses his job. Not good basis for a recommendation.

Long hours - little recognition and micro management from Executive Team.

The business model steers away from a person centred approach. It only cares about hitting targets (which are often unrealistic) and doesn't give a damn about the staff. With regards to a specific service the Trust compact has not been adhered to at all by the Trust and although this has been highlighted on many occasions the Chief Exec/EMT and management choose to ignore it. I don't even know why I' m wasting my time highlighting it yet again.

Constant staff shortages, putting patients and staff at risk, low morale, hypocritical upper management.

The Trust wastes large amounts of money on staff who are either incapable of fulfilling their job description or whom have excessive sickness records . This places a very large burden on staff whom are reliable and committed to their job.

Management.

Everyone is stressed and burnt out.

Too much change too quick - leading to chaos at work. Often do not feel valued as a member of staff. Bullying of the work force by managers and lack of support - lack of regard by higher managers re clients despite the Compact putting them at centre.

I have worked for this Trust since mid-December 2014 I am still not receiving the correct pay. I have had frequent contact with the relevant departments who appear to be entirely disinterested and seem to expect me to sort out this problem.

Many services seem to be in a state of considerable flux and instability at present. Although the Trust reports to put service users at the heart of everything, I see service users often having less choice in terms of where they are seen and when. The service commissioners and GP's often want anyone they refer to be given a service but given the constraints on services and often small number of staff trying to deliver these, allowing everyone even an initial assessment will inevitably lead to increasing delays for those patients who are more severe and have more complex needs. I see staff morale falling and experienced clinicians looking for other posts. Staff often do not feel valued and are often feeling undermined by changes which although they are told they have had input towards (RPIWs) etc, they perceive as being decided before the event and then find the terms of reference for the projects are changed without further consultation.

As previously stated the Trust has no value of its staff. Yes there is regards and dare I say respect at a local level but from a more strategic level and in the directorate levels there is little of this for the foot soldiers. The Trust is again interested in its balance books. An extraordinary pay rise for a chief executive whilst nursing staff at the front edge have to do exponentially more with no increase in resources but rather a reduction. Would you work in a place like this? Come on!

Very poor culture and working environment. All care driven by targets, money and paperwork. Staff managed by fear for job security. Culture of blame.

Over the past 2 years after meetings and how things would change for the better things have got so bad that staff are off ill with stress or leave. Management don’t have a clue and will not listen to the front line staff (Targets need to be met). I have worked over 20 years for the NHS and I now am feeling I don’t want to come into work and NEVER had that feeling before.

Jobs seem to be filled by people on 'secondment' without interview and then the people who are seconded just stay in post, so competitive interviews are not used to fill senior posts. Staff are over burdened with pointless stats and tasks to hit targets.

Mental Health Management have little clinical or personal skills, clinical training or care for patients.

Not specifically an issue with TEWV or the service I work in. I wouldn’t want any family member of mine to be subject to the unrealistic expectations and high stress levels that working in inpatient services as a whole require in the NHS.

Some Management are bullies.

Staff are not valued. Not family friendly.

After having suffered a serious physical assault when working on inpatient ward and then being sacked due to sick leave then having to retain services of a solicitor to attend a tribunal in order to be reinstated I would not recommend TEWV as an employer even to my worst enemy. Would you?

TEWV does not appear to value staff and staff are often regarded as a human resource not individuals.

Our team have been in a constant state of uncertainty for over 2 years due to impossible demands from commissioners, it is demoralising and no matter how hard you work you never feel as though it is enough.

I am not valued or respected by line managers.

Staff are not supported with managing workloads in safe numbers and demands are un-manageable, when brought to the attention of senior support staff and managers little is done to support staff, more cases are put onto staff caseloads in increasing numbers that are unrealistic and unachievable.

My stress levels are through the roof working for this area which is disorganised and short staffed. I now would not even recommend anyone work within the area of health.

Staff face discrimination regarding tattoos, hair colour and lifestyle choices are not respected.

The caseloads are far too pressurising for people and sickness rates are high.

Unorganised.

The current situation is being managed poorly with the remaining staff becoming unmotivated and experiencing high levels of workplace stress that are being ignored by the management team with a response given to remain focused on unrealistic and unachievable targets as opposed to delivering a quality service and an effective pathway of treatment.

You are asked to do more and more for no recognition of what you are doing and have been doing - and any small mistakes, or perceived lack of working from other members of staff, is immediately highlighted with management, you feel less recognition for your skills and the cycle of despair continues.

It is an organisation so obsessed with change that staff feel overwhelmed and concerns about the impact on patient care are not listened to.

I have worked for TEWV for 18 years and over the last 6 years there has been a decline in the way staff are treated and valued. The Trust is now too focused on business and has a staff blame culture even if staff are working very hard. Very little praise is given and opportunities to develop have been reduced due to a focus on performance. I am aware this is not the case on all services which again makes this unfair.

The Trust has become an uncaring place to work. It does not care about staff at all. It treats staff very shabbily.

The service I work in is not TEWV only so is not completely governed by TEWV. The staff in this service are very stressed and the management ways of working do not consider this in their communication with the staff within the service. My previous working within just TEWV service would result in a very different answer to this question.
I feel that there is more stress in the NHS workplace especially Admin and although more nurses are occasionally recruited Admin staff are still expected to take on the workload that they represent without any thought how it impacts on their health and wellbeing. Admin staff are constantly being told that there is no money even when people have retired or left the service they are not replaced putting extra pressure on the Admin.

The managers are really quite poor - they are unable to provide us with the necessary means to do our jobs e.g. good effective computerised programmes that allow speed and efficiency; sound proofed rooms etc.

Staff Experience – Friends and Family Test Quarter 1 2015

**ITEM 16**

**FOR GENERAL RELEASE**

# BOARD OF DIRECTORS

**Date of Meeting:** 23th July 2015

**Title:** Monitor Risk Assessment Framework Report

**Lead:** Phil Bellas, Trust Secretary

**Report for:** Decision

## This report includes/supports the following areas:

| STRATEGIC GOALS: | ✓ |
|---|---|
| To provide excellent services working with the individual users of our services and their carers to promote recovery and well being | |
| To continuously improve the quality and value of our work | |
| To recruit, develop and retain a skilled and motivated workforce | |
| To have effective partnerships with local, national and international organisations for the benefit of our communities | |
| To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities | ✓ |

| CQC REGISTRATION: Outcomes (✓) | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | ✓ | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | | Staffing | | Supporting workers | |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | ✓ | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | ✓ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

**BOARD OF DIRECTORS**

**Date of Meeting:** **23rd July 2015**

**Title:** **Monitor Risk Assessment Framework Report**

## 1. INTRODUCTION & PURPOSE

1.1 The purpose of this report is to seek the Board's approval of the Trust's proposed submission to Monitor under the Risk Assessment Framework (RAF) for Quarter 1, 2015/16 (period covering 1st April 2015 to 30th June 2015).

1.2 The report also provides a summary of the proposed changes to the RAF which are due to be introduced during Quarter 2, 2015/16.

## 2. BACKGROUND INFORMATION

2.1 The Risk Assessment Framework provides details of the in-year information which the Trust must submit to Monitor, based on its risk ratings.

2.2 The information required by Monitor in the Quarter 1 submission is as follows:

(a) Quarterly financials.

(b) Year-to-date financials.

(c) Information on forward financial events (e.g. notification of material transactions).

(d) A requirement to inform Monitor if capital expenditure for the remainder of the year is likely to diverge by +/- 15% from the amount in the Annual Plan.

(e) Self certification that "The Board anticipates that the Trust will continue to maintain a Continuity of Service Risk Rating of at least 3 over the next 12 months."

(f) Information to enable Monitor to assess organisational governance including service performance and care quality.

(g) Self certification of two governance statements as follows:

- "The Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards." (Statement A)

- "The Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Risk Assessment Framework page 22 Diagram 6) which have not already been reported." (Statement B)

(h) A declaration on the number of subsidiaries which are consolidated in the financial results submitted.

(i) The results of any Governor elections.

(j) Information on Executive team turnover which is used as a potential indicator of quality governance concerns.

(k) Exception reports to be provided to Monitor at any time when risks to compliance with the financial and governance licence conditions arise.

2.3 The Board will recall that at Quarter 4 2014/15 the Trust had:
(a) A Continuity of Service Risk Rating (CoSRR) of 4 (out of 4).
(b) A "Green" Governance Risk Rating.

2.4 The Trust is required to submit its Quarter 1 Risk Assessment Framework Return by 31st July 2015.

## 3. KEY ISSUES:

***The Quarter 1, 2015/16, Risk Assessment Framework Submission***

Continuity of Service Risk Rating (CoSRR)

3.1 The Board is asked to note that the Trust's financial position and the declaration on the CoSRR are due for consideration under agenda item 13.

Governance Targets and Indicators and Declarations

3.2 Details of the healthcare targets and indicators, together with Monitor's thresholds and weightings, supporting the assessment of the Trust's Quarter 1 Governance Risk Rating are set out in Annex 1 to this report.

3.3 The scoring of the metrics is based on the information provided in the Performance Dashboard report (see agenda item 14).

3.4 It is considered that the Board is able to sign off both governance declarations for Quarter 1, 2015/16.

Subsidiary Declaration

3.5 It is proposed to advise Monitor that no subsidiaries are consolidated in the financial results submitted as Positive Individualised Proactive Support Ltd has not yet commenced trading.

Governor Elections

3.6 The Board is asked to note that no elections to the Council of Governors were held during Quarter 1, 2015/16.

Quality Governance

3.7 The information required by Monitor on Executive Team turnover is as follows:

| Executive Directors | Actual for Quarter ending 30/6/15 |
|---|---|
| Total number of Executive posts on the Board (voting) | 5 |
| Number of posts currently vacant | 0 |
| Number of posts currently filled by interim appointments | 0 |
| Number of resignations in quarter | 0 |
| Number of appointments in quarter | 0 |

Exception Report and Other Information to be provided to Monitor

3.8 In accordance with the requirements of the RAF, the Board is asked to approve an exception report, as set out in Annex 2 to this report, with regard to the compliance issues raised by the CQC following its inspection of Forensic Learning Disability Services at Roseberry Park in March 2014 and its Trustwide inspection in January 2015.

***Proposed Changes to the 2015 Risk Assessment Framework***

3.9 Monitor is proposing to strengthen its regulatory regime, in response to the financial challenges facing the NHS, through changes to the Risk Assessment Framework.

3.10 The proposed changes to the RAF are summarised in Annex 3 to this report. They are intended to enable regulatory action to be taken earlier if a Foundation Trust is in deficit, failing to deliver its financial plan or not providing value for money.

3.11 The Board is asked to note that, following a review by the Finance Directorate, the proposed changes, where details are known, are not expected to impact negatively on the Trust's risk ratings.

3.11 Monitor is planning to publish a revised version of the RAF in Quarter 2, 2015/16 with any changes made taking immediate effect.

## 4. IMPLICATIONS / RISKS:

4.1 **Quality:** No risks to quality have been identified.

4.2 **Financial:** This issue is covered in the report of the Director of Finance under agenda item 13.

4.3 **Legal and Constitutional:** No legal or constitutional risks have been identified.

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

4.5 **Other Risks:** No other risks have been identified.

## 5. CONCLUSIONS

5.1 It is considered that the Trust is compliant with the requirements of the Risk Assessment Framework at Quarter 1, 2015/16.

## 6. RECOMMENDATIONS

6.1 The Board of Directors is asked to:

(a) Approve the Trust's Quarter 1, 2015/16, Risk Assessment Framework submission to Monitor including:

- The signing off of both Governance Statements.
- The Information on Executive Team turnover.
- The signing off of the declaration that no subsidiaries are consolidated in the financial return.
- The exception report set out in Annex 2 to this report.

(b) Note the proposed changes to the Risk Assessment Framework which are due to be introduced in Quarter 2, 2015/16.

**Phil Bellas,**
**Trust Secretary**

**Background Papers:**
***Risk Assessment Framework***

**Annex 1**

## Analysis of Governance Risk Rating, Quarter 1, 2015/16

| Component | Threshold | Weighting | Outcome for Quarter 1 | Score for Quarter 1 |
|---|---|---|---|---|
| Mental Health Targets - | | | | |
| ▪ Care Programme Approach (CPA) follow up within 7 days of discharge | >95% | 1.0 | Target achieved | 0 |
| ▪ Care Programme Approach (CPA) formal review within 12 months | >95% | 1.0 | Target achieved | 0 |
| ▪ Minimising delayed transfers of care | <=7.5% | 1.0 | Target achieved | 0 |
| ▪ Admissions to inpatient services had access to crisis resolution home treatment teams | >95% | 1.0 | Target achieved | 0 |
| ▪ Meeting commitment to serve new psychosis cases by early intervention teams | >95% | 1.0 | Target achieved | 0 |
| ▪ Data Completeness: identifiers | >97% | 1.0 | Target achieved | 0 |
| ▪ Data Completeness: outcomes | >50% | 1.0 | Target achieved | 0 |
| Compliance with requirements regarding access to healthcare for people with a learning disability. | n/a | 1.0 | Not required for the Quarter 1 return | - |
| Risk of, or actual failure, to deliver Commissioner Requested Services | n/a | Report by exception | No | - |
| Date of last CQC Inspection | n/a | - | January 2015 | - |
| CQC compliance action outstanding (as at time of submission) | n/a | Report by exception | Yes | Exception report to be submitted |
| CQC enforcement notice within the last 12 months (as at time of submission) | n/a | Report by exception | No | - |
| CQC enforcement action (including notices) currently in effect (as at time of submission) | n/a | Report by exception | No | - |

| | | | | |
|---|---|---|---|---|
| Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) | n/a | Report by exception | Yes | Exception report to be submitted |
| Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) | n/a | Report by exception | No | - |
| Overall rating from CQC at time of submission | n/a | - | Good | - |
| CQC recommendation to place Trust into special measures (as at date of submission) | n/a | - | No | - |
| Trust unable to declare ongoing compliance with minimum standards of CQC registration | n/a | Report by exception | No | - |
| | | | **Total Score** | **0.0** |

(Note: The Trust's positions on the EIP and IAPT access indicators, introduced in the Risk Assessment Framework 2015, are not due to be reported until Quarters 3 and 4, 2015/16, respectively.)

**Annex 2**

**Draft Exception Report**

(1) At Quarter 4, 2014/15 the Trust advised Monitor that it had declared its Forensic Learning Disability services at Roseberry Park, Middlesbrough to be fully compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 following action taken to address compliance issues and "moderate concerns" raised by the Care Quality Commission (CQC) following an inspection in March 2014.

Since that time the Trust has been awaiting a follow up inspection by the CQC so that the compliance issues and concerns can be formally signed off. The CQC has yet to confirm the arrangements for this re-inspection.

(2) On 11th May 2015 the CQC published its reports on the inspection of the Trust in January 2015.

Whilst the overall rating provided to the Trust was "Good", the CQC issued requirement notices with regard to compliance with regulations 10, 12, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Trust has developed an action plan to address these compliance issues, a copy of which had been provided to Monitor.

As at 30th June 2015 all the actions have either been completed or are on track for completion in accordance with plan.

**Annex 3**

## Summary of Proposed Changes to the Risk Assessment Framework

1 **New Sustainability and Performance Risk Rating:**
Monitor is proposing to replace the Continuity of Service Risk Rating (CoSRR) with a new Sustainability and Performance Risk Rating (S&PRR).

This new rating will comprise four measures:

- Capital Servicing Capacity (as per the present CoSRR)
- Liquidity (as per the present CoSRR)
- I&E Margin
- Variance from Plan

Details of the S&PRR including the rating categories and related regulatory activities are set out in the following tables:

| | Financial criteria | Weight (%) | Metric | Rating categories 1[2] | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|
| No change – Continuity of Service | Balance sheet sustainability | 25 | Capital Service Capacity (times) | Less than 1.25x | 1.25x – 1.75x | 1.75x-2.5x | Greater than 2.5x |
| | Liquidity | 25 | Liquidity (days) | Worse than (14) days | (14)-(7) days | (7)-0 days | Greater than 0 days |
| New triggers – Financial efficiency | Underlying performance | 25 | I&E margin[1] (%) | Worse than (1)% | (1)–0% | 0-1% | Greater than 1% |
| | Variance from plan | 25 (15) | Variance in I&E margin as a % of income[1] | Worse than (2)% | (2)-(1)% | (1) - 0% | Greater than 0% |
| | | 25 (10) | Variance in capital expenditure | Greater than 25% | 25-20% | 20-10% | 10% |

[1] calculated as I&E operating surplus(deficit) / total operating income
[2] scoring a '1' on any metric except variance in capital expenditure will cap the weighted rating to 2, leading to potential investigation

| Risk Rating | Description | Regulatory activity |
|---|---|---|
| 4 | No evident concerns | None |
| 3 | Emerging or minor concerns requiring potential scrutiny | Potential improvement support |
| 2 | Material risk | Likely investigation<br>Potential improvement support |
| 1 | Significant risk | Investigation (in all but exceptional circumstances)<br>Potential improvement support |

2 **Governance Risk Rating:**

It is also proposed to include an additional measure in the Governance Risk Rating linked to value for money.

This will enable Monitor to undertake an investigation if it considers a Foundation Trust is demonstrating inefficient or uneconomical spend (actual or forecast) against published benchmarks.

Details of the proposed new measure will be published in due course.

3 **Changes to the NHS Foundation Trust Accounting Officer Memorandum:**

Monitor intends to amend the Accounting Officer Memorandum as follows:

(a) To update paragraph 7 to set out that the Accounting Officer must ensure:
- The Foundation Trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation.
- Financial considerations are fully taken into account in decisions by the NHS foundation trust

(b) To update paragraph 8 to reference the Accounting Officer's duty to deliver prudent and economical administration in line with the principles set out in 'Managing Public Money'.

Monitor will also be reviewing existing obligations to ensure that they require Foundation Trusts to deliver effective management systems, including financial monitoring and control systems.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

**FOR GENERAL RELEASE** **ITEM 17**

**BOARD OF DIRECTORS**

**Date of Meeting:** **Thursday 23 July 2015**

**Title:** **Governance: Quarterly Progress Report on Governance Action Plans**

**Lead Director:** **Martin Barkley, Chief Executive**

**Report for:** **Consideration**

## This report includes/supports the following areas:

| **STRATEGIC GOALS:** | |
|---|---|
| **To provide excellent services working with the individual users of our services and their carers to promote recovery and well being** | ✓ |
| **To continuously improve the quality and value of our work** | ✓ |
| **To recruit, develop and retain a skilled and motivated workforce** | |
| **To have effective partnerships with local, national and international organisations for the benefit of our communities** | |
| **To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities** | ✓ |

| **CQC REGISTRATION: Outcomes (✓)** | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | | Staffing | | Supporting workers | |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | ✓ | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | ✓ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

**BOARD OF DIRECTORS**

**Date of Meeting:** **Thursday 23 July 2015**

**Title:** **Governance: Quarterly Progress Report on Governance Action Plans**

## 1. PURPOSE OF THE REPORT

1.1 The purpose of this report is to inform the Board of the progress being made in completing the action plans which the Board approved to strengthen the governance arrangements in the Trust. The updates are shown in red.

## 2. BACKGROUND

2.1 Quality governance arrangements

The Board commissioned Deloitte to undertake a follow-up review of quality governance arrangements, following the first review that Deloitte carried out which was reported to the Trust at the end of August 2013. A follow-up report was reported to the Board in July 2014.

2.2 Independent review of Board governance arrangements

The Board will also recall that it commissioned Deloitte to undertake an independent review of its Board governance arrangements. This report was issued to the Trust on 15 April 2014 and presented to the Board at its meeting in June, along with an agreed response to the recommendations contained in that report. Those recommendations and the Trust's response are also reflected in the action plan attached as Annex 1.

2.3 As agreed at the July 2014 meeting of the Board, the action plan shown as Annex 1 also contains those actions that remain outstanding / in progress from the August 2013 Deloitte report, together with those handful of recommendations / actions that remain outstanding from the Audit North / Allsopp / Parker reports. It also now includes actions outstanding from the work the Board did when reviewing itself in answering "How does the Board know the Trust is working effectively to improve patient care", as agreed at the Board meeting in January 2015. Thus there is now a single consolidated quality governance action plan.

## 3. KEY ISSUES

3.1 The Board will see that most of the actions in the action plan are on target, nevertheless some slippage has occurred. The most significant date to change is the completion of the DATIX project. The extra time is to enable three series of tests, not just one, and much more support to staff during an extended roll-out to improve uptake and effective use of the extra functionality.

3.2 Actions 1, 4, 8, 9, 20, 22 and 27 of the Deloitte Review of Board action plan have been deleted because they were reported as complete at the April 2015 meeting.

3.3 Similarly, actions14, 15 and 19 of the Deloitte Quality Governance Review report action plan.

3.4 Similarly, action 36 from the Board self-assessment action plan.

## 4. IMPLICATIONS AND RISKS

4.1 **Quality:** The implementation and achievement of the action plan shown as Annex 1 is likely to lead to an increase in the quality of service provided and certainly lead to an increase in assurance about the quality of service provided.

4.2 **Financial:** No further costs identified except £45,000 to extend the DATIX project.

4.3 **Legal & Constitutional:** The implementation of the action plan is likely to strengthen and improve the level of compliance the Trust has in terms of its licence to operate as a Foundation Trust.

4.4 **Equality and Diversity:** No direct equality and diversity implications have been identified.

4.5 **Other Risks:** No other direct implications or risks have been identified.

## 5. RECOMMENDATION

5.1 The Board is asked to:

- Receive and note the progress report shown as Annex 1.
- Agree that this report and action plan are shared with Monitor through our Monitor Relationship Manager.

**Martin Barkley**
**Chief Executive**

**ANNEX 1**

# INDEPENDENT REVIEW OF (BOARD) GOVERNANCE ARRANGEMENTS APRIL 2014: STANDARD ACTION PLAN

**PLAN LOCATION/TEAM: BOARD PLAN DEVELOPED BY: CHIEF EXECUTIVE DATE PLAN AGREED: 29 JULY 2014**

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
|---|---|---|---|---|---|---|---|
| **3** | Consider spending time on team development as part of the forward programme of Board seminars (no end date is assigned and this is an ongoing consideration for 2014/15). | Board members work effectively together. | Arrange team development session/s at Board Seminars. | Chairman/ Trust Sec | By November 2015 | Positive feedback/ Board evaluation. | This will be done in November, the first available slot following the appointment of the new Director of Nursing and Governance. |
| **15** | Ensure that the new processes applied to SI action plans are rolled out to other types of action plans across the Trust. | Ensure consistency of follow-up and implementation. | Implement new format action plans and progress reporting. | CE | From February 2014 | Action plans and progress reports. | **Complete** |
| **16** | Ensure that there are clear channels of communication for lessons learned across localities following the SDG meetings. | Improve quality from effective dissemination of lessons learned. | Publish monthly "lessons learnt" bulletin. | Dir of N&G | January 2015 | Bulletins published. | **Partial - The bulletin is being revised based on feedback.** |
| **17** | The Board should work with the Governors' Task and Finish Group on holding to account to consider additional ways in which the Governors and NEDs can interact (being mindful of the need to | Increase appropriate interactions between Governors and NEDs. | Establish a new Task and Finish Group to agree how a better balance between reporting and discussion can be | Trust Sec | March 2015 | Report agreed by Board and Council of Governors. | **Complete** |

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
|---|---|---|---|---|---|---|---|
| | utilise existing opportunities as much as possible, rather than creating additional demands on NED time). | | achieved. | | | | |
| **18** | The Board should seek to further promote and communicate the mechanisms by which service users can provide the Trust with feedback. In addition, it is important that feedback loops are effectively closed, so that service users are clear on what has been done to address concerns raised. | Ensure that feedback from service users is easily received and used to improve quality. | Increase service user group arrangements in AMH. | CE | December 2015 | Report on new arrangements. | **Review has started in NY. Quotes being obtained to review in D&D and Tees.** |
| | | | Implement patient experience workplan in Quality Strategy. | Dir of N&G | Achieve milestones | Assurance reports to QuAC. | **Complete** |
| **25** | As part of the implementation of the IIC it is important that the Board understands staff concerns regarding data accessibility and usability. This will therefore ensure that the new system is appropriately tailored to enable all services to access and manage their data effectively and efficiently. | Ensure that information is easily accessible and relevant to staff. | Proceed with development of IIC. | Dir of Fin/ Dir of P&P | December 2015 | Feedback on use of IIC. | On schedule |
| **26** | Move the Board and its committees to paperless meetings in a supportive and phased basis. | Reduce cost and time of admin re. agenda papers. | Develop and agree technology solution. | Dir of Fin | September 2014 | Agenda papers not sent out. | **Complete** |

# QUALITY GOVERNANCE ARRANGEMENTS: STANDARD ACTION PLAN

**PLAN LOCATION/TEAM: BOARD PLAN DEVELOPED BY: CHIEF EXECUTIVE DATE PLAN AGREED: 29 JULY 2014**

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
|---|---|---|---|---|---|---|---|
| 1 | **August 2013: Recommendation 6**<br>Ensure that a singular performance reporting scorecard is used so that performance against core goals is well disseminated throughout the Trust. The strategic scorecard seen by the Board should consist of sub-"layers" which are expanded scorecards aligned to localities and service lines. | The Trust has a monthly dashboard which demonstrates performance against a key set of indicators (linked to each Strategic Goal). The development of sub layers for each locality and service is in development via the Integrated Information System. It is already possible to use the IIC to drill down from organisational performance to locality / ward / team for the majority of indicators. The report to the Board is mainly high level, strategic with increasing levels of detail at Locality and Directorate levels. The "Red" indicators will be escalated, ultimately to the Board. | Content of sub-layers agreed. Develop further the IIC. | Dir of P&P | September 2014 | Ward and team dashboards issued. | **Complete** |
| | | The Board will establish the layered scorecard approach | | | | | Reports at Directorate level are published. |

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
|---|---|---|---|---|---|---|---|
| | | above to the new Quality Strategy from April 2014. | | | | | |
| 2 | **August 2013: Recommendation 8**<br>Ensure a combined risk management system is implemented throughout the Trust. This should incorporate complaints, PALS, claims, Risk Registers, Incident Reporting, FOI, PHSO. This will enable robust escalation of issues, reporting, triangulation, hot-spot identification and better "horizon-scanning". | The enhancement of DATIX is a pre-existing key priority in the Trust's Information Strategy. Work on expanding the use of DATIX to incorporate | Design integrated reports, standardising data systems ready for DATIX use and scoping the extended use of the DATIX system. | Dir of N&G | March 2015 | Report formats in place.<br><br>Standardised data system in place. | **Complete – Note: Reports are being reviewed as revised in line with staff feedback to ensure optimum effectiveness.** |
| | | | Expand use of DATIX and configure new modules and train staff in new systems. | | June 2015<br><br>December 2015 | New modules configured.<br><br>Staff trained. | **The configuration of the new modules is complete and the phase of workplace testing and staff training has commenced. Further work is planned to develop the use of the risk management system.** |
| | | | Complete server infrastructure work. | Dir of Fin | September 2014 | Infrastructure in place. | Complete |
| | | | Develop PM3 to secure resource. | Dir of Fin/ Dir of N&G | July 2014 | PM3 approved. | Complete |
| 3 | **August 2013: Recommendation 12**<br>All front-line services must own their own local risk registers and there must be clear escalation to the corporate RR and BAF. | Each ward, community team, etc. will have their own risk log. As there is a new entry, or concerns about an existing log are | Quality assure Directorate Risk Registers. | Trust Sec/ COO | May 2014 | Independent report received. | Complete |
| | | | Train Heads of Service. | Trust Sec/ | September 2014 | Attendance list. | Complete |

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
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| | | increased, the Head of Service will be notified for inclusion in the Directorate Risk Register with all changes to the Directorate Risk Register that occur in the month being reported to the Locality Management and Governance Board. | | COO | | | |
| | | | Update Risk Registers. | Trust Sec/ COO | December 2014 | Updated registers received. | To follow from training. This has been delayed to coincide with when this functionality on DATIX goes live to avoid doing things twice in a relatively short period of time. |
| **4** | **August 2013: Recommendation 21** The new risk management interface (DATIX, Safeguard, etc.) should be aligned to the IIC to ensure joined up and systematic reporting and escalation routes. (Please also see R8). | Agreed. This will be done as soon as possible. | Plan in place for the data feed from the new risk management interface into the IIC to be available for Trust wide roll-out of the new system. | Dir of Fin | June 2014 | Plan exists. | Complete |
| | | | PM3 approved and investment of £160k. | Dir of Fin | May 2014 | PM3 approved. | Complete |
| | | | Join up DATIX with IIC re. risk management interface. | Dir of Fin | March 2016 | | On schedule |
| **5** | **August 2013: Recommendation 30** Increase standardisation at ward level through; the use of governance dashboards, standard agenda items for team meetings and more effective feedback process on patient safety incidents and complaints. | Agreed. Ward performance dashboards are being developed and will be incorporated as a priority into the IIC development. | Develop IIC to produce ward and team dashboards. | Dir of P&P | September 2014 | Dashboards available. | Complete |
| | | A statement clearly articulating the expectations of what it means to be a Ward | A 3P will be undertaken to develop a statement setting out the expectations of | COO | March 2014 | Statement exists. | Statement completed and disseminated to ward managers. |

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
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| | | Manager in TEWV is also at the early stages of development from which standard work will develop including standard agendas, etc. Additionally it will also help inform the content of Personal Development Plans for existing Ward Managers and the training programme the Trust should provide for Band 6 inpatient nursing staff to prepare them not only to deputise for the Ward Manager, but also to secure promotion (should they wish to do so). | ward managers. | | | | **PM3 Project agreed by EMT May 2015.** |
| | | This will be accompanied by the development and introduction of standard work, including templates for ward / team meetings setting out standard agenda items, which will include complaints, PALS, Patient Experience feedback, patient incidents and | Develop written guidance and templates. | COO | Q2 2015/16 | Guidance published. | A PM3 has been developed and will be submitted to EMT in May 2015. This is in line with timescales agreed in the business plan. The standard processes for communication on daily management have been developed and are |

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
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| | | SUIs. | | | | | live in a number of areas – this includes patient experience, incidents, SUIs, etc. The roll-out will be completed by the new Locality Heads of Nursing and Locality Managers. |
| **6** | **August 2013: Recommendation 31**<br>Ensure that all ward managers have protected time allocated for governance. | All ward managers are "supernumerary" and are not part of the regular shift pattern as part of the planned nurse staffing levels. The ward managers are usually expected to work 9.00 am - 5.00 pm Monday - Friday and one of the rationale for that is to ensure that they do have time to focus on their governance and other management responsibilities. What is considered necessary is to brief ward managers in detail about what is expected of them with regard to their governance responsibilities. In | Ensure that all ward managers are supernumerary and have protected time for governance. | COO | Q2 2015/16 | | All ward managers are supernumerary. The actions in Item 5 above will support the aim of providing clear processes for managing time to support governance activities. As noted above, this will be rolled out by end of Q2 2015/16. |

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
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| | | addition standard agenda items for ward meetings will also be developed and issued as part of the work the Trust is doing on being clear about "expectations on a TEWV ward manager" and the development of a model ward. | | | | | |
| 7 | **August 2013: Recommendation 32**<br>Reinforce standardised governance processes at the level of community teams and ensure that a specific set of early alerts and triggers are used to identify hot-spots. (See Norfolk Community Services Trigger Tool). | Agreed that it is very important that the Trust develops standard processes for community teams which includes early alerts and triggers being used to identify and report hot-spots. | Communication plan developed and agreed.<br><br>Communication plan implemented September – December. | COO<br><br>COO | August 2014<br><br>December 2014 | Plan in place.<br><br>Plan completed. | Community Team dashboard was launched late October on IIC. Triggers have been established through the Trust's Risk and Escalation procedure. |
| 8 | **August 2013: Recommendation 37**<br>A new electronic reporting interface will provide improved escalation and automated report generation. Local teams should also be able to extract their own reports from both DATIX and the IIC. | This will be implemented as soon as possible. As previously mentioned, the DATIX workstream in the Information Strategy is being brought forward as much as possible.<br><br>Local teams can already use the IIC to allow them to understand their performance against | Produce ward and team dashboard reports from IIC. | Dir of Fin/ Dir of P&P | September 2014 | Reports available. | The ward and team dashboard reports were published end of October 2014.<br><br>**Interface between DATIX and IIC to be developed.** |

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
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| | | the Trust Board monthly dashboard Indicators using the "drill down" facility of the IIC. As additional systems / reports are generated on IIC this facility will be expanded. | | | | | |
| 9 | **August 2013: Recommendation 39**<br>The Trust (who have dedicated a resource to this prior to our review) should now start demonstrating that they are recruiting for values as well as capability. | The pre-existing project is continuing which has the specific aim of enabling the Trust to test for attitudes / values and applicant literacy and numeracy levels, during key stages of the recruitment process. | Evaluate Phase 1.<br><br>Evaluate Phase 2. | Dir of HR | July 2014<br><br>March 2016 | Report to EMT. | Complete - Recruiting for values project complete and is being implemented re apt of all frontline staff.<br>However, an additional phase to the project has been added which will complete March 2016. |
| | | | Roll-out to all staff recruitment (subject to EMT approval). | Dir of HR | December 2014 | Report to EMT. | Started |
| 10 | **August 2013: Recommendation 41**<br>The Trust should aim for a 100% compliance rate for mandatory and statutory training of all staff in active employment. The 100% tolerance should also be applied to all bank staff. | The Trust does in fact aim for 100% compliance rate for mandatory and statutory training for all staff in active employment which includes bank workers. For practical purposes the benchmark of 95% is used recognising | Develop and put in place arrangements that will ensure the target is met. | CE | September 2014 | Target achieved by March 2015. | Robust discussion has taken place at EMT on the importance of meeting this standard. There are data quality issues therefore teams that attain 95% or more will be green; 88-94% |

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
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| | | that 100% will not be possible because of various staff being on long term sick leave, maternity leave or other exceptional extenuating circumstances.<br><br>The Trust has reached agreement with Trade Union representatives that annual increments under Agenda for Change are conditional on the member of staff completing their mandatory training and having an annual appraisal. This was introduced approximately twelve months ago. | | | | | amber; 87% or less will be red. This will facilitate performance management of outliers without data quality issues distracting from the need to focus on the 87% or less teams. |
| **11** | **August 2013: Recommendation 42**<br>There should be absolute zero tolerance on staff starting work without local induction. | Local induction is an essential part of starting a new job and the local induction is required to take place on and from Day 1. A quality check on local induction arrangements will be undertaken in Quarter 4 2013 /14. | Develop and put in place arrangements that will ensure the target is met | CE | September 2014 | Quarterly workforce report shows 95% attainment. | More detailed exception reports in place to easily identify the outliers and address reporting deficiencies. |

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
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| | | The 2013 /14 Q4 Quarterly Workforce Report to the Board will include a new KPI concerning local induction taking place on the first day of employment in the Trust. | | | | | |
| **12** | **July 2014: Recommendations 1 and 5**<br>The Trust develop a communication programme using a range of channels to formally launch and raise awareness of the Quality Strategy. | To ensure a good level of awareness and knowledge of the key elements of the Trust's Quality Strategy. | Develop communication plan.<br><br>Implement communication plan. | Dir of N&G<br><br>Dir of N&G/ CE | August 2014<br><br>September 2014 to December 2014 | Plan agreed by EMT.<br><br>Plan completed.<br><br>Staff Survey results. | **Complete – Staff briefings were carried out and briefing leaflets distributed. Further awareness raising planned for autumn 2015 in line with engaging York and Selby services.** |
| **13** | **July 2014: Recommendation 12**<br>The Risk Management Policy is reissued across the Trust with facilitated training and guidance to the QuAGs. | Heads of Service have a good understanding on the application of TEWV's Risk Management Policy at Directorate level and below. | Please see No. 3 above. | COO / Trust Sec | December 2014 | Attendance list and quality of Directorate Risk Registers. | Postponed to coincide with DATIX enhanced functionality coming on stream. |
| **16** | **July 2014: Recommendation 28**<br>The Trust should introduce fully embedded Deputy Directors of Nursing within localities aligned to the Deputy Medical Directors. | Nursing profession has the capacity to contribute to and be accountable for quality governance in each locality. | Review the structure / duties and deployment of Deputy / Assistant Directors of Nursing. | Dir of N&G/ CE | November 2014 | Revised arrangement agreed by EMT. | **Complete – Deputy and Associate Directors of Nursing roles have been reviewed and new roles established.** |

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
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| | | | | | | | **Roles for Locality Heads of Nursing established and two of the five posts have been recruited to. Final recruitment will be completed in Q2.** |
| **17** | **July 2014: Recommendation 30**<br>The Trust audit the frequency and content of ward meetings to seek assurance in this area. | Effective ward meetings take place regularly. | Issue guidance about ward meetings.<br><br>Carry out audit – (commission internal auditors). | COO<br><br>COO | August 2014<br><br>January 2015 | Guidance issued.<br><br>Audit report available for consideration | In progress. Linked to Actions 5 and 6. Ward Managers are piloting a new format Daily Management. This will be rolled out from Q4.<br><br>To be agreed as part of audit programme. |
| **18** | **July 2014: Recommendation 33**<br>Improve quality of (some of) assurance reporting provided to QuAC to better facilitate challenge and discussion e.g. present trend data for some metrics "per bed day" to enable a direct comparison.<br><br>Consider reducing the frequency of reporting items to QuAC, in particular consider LMGB representatives attending on a rolling basis. | QuAC receives informative assurance reports that clearly demonstrate any assurance issues.<br>Agendas of QuAC are such that they can be effectively transacted within 3 hours. | Review Terms of Reference of QuAC.<br><br>Establish Information Analyst capacity and capability in N&G Directorate.<br><br>Review content of assurance reports to ensure they clearly demonstrate any assurance issues. | CE/ Dir of N&G<br><br>Dir of N&G<br><br>Dir of N&G | August 2014<br><br>March 2015<br><br>December 2014 | New Terms of Reference.<br><br>Staff in post.<br><br>Assurance reports agreed by QuAC. | Complete<br><br>**Complete – Quality Data Team established and operational.**<br><br>**Complete – Suite of reports established and development programme for all** |

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
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| | | | | | | | **reports to be revised is in place.** |
| **20** | **Board QGF self-assessment**<br>The quality of actions plans in response to SUIs and complaints to be improved ensuring they are relevant, proportionate and SMART. | Action plans have SMART actions. | Four more workshops to be arranged on action planning. | COO/ Dir of N&G | ~~May 2015~~ **March 2016** | Attendance lists. | **In development planning for end of 2015/16.** |
| **21** | **Audit North 7.1**<br>The Trust should consider ways to overcome geographical barriers and to help ensure that attendance at meetings represents the most efficient use of staff members' time and engages the maximum number of relevant employees. For example, implementing video and telephone conferencing facilities at all Trust sites for use in meetings. | Reduce travel time and costs and improve use of time. | Implement "Reduce travel expenditure" project. | Head of Psych Therap-ies & AHP/CE | March 2016 | Expenditure on travel. | On schedule |
| **22** | **Audit North 9.1**<br>Through consideration of the pros and cons, management should evaluate whether Tier 4 CAMHS and EIP is most effectively managed through alignment with North Yorkshire. Evaluation should involve consultation with, and consideration of the views of, current management teams and staff members responsible for provision of the services. | Optimal management arrangements for Tier 4 CAMHS. | Change management arrangements for EIP.<br><br>Tier 4 remains under consideration. | COO<br><br>COO | April 2014<br><br>Ongoing | Structure in place.<br><br>N/A | Complete<br><br>N/A |
| **24** | **Board QGF self-assessment**<br>Can we reduce the amount of time | Improve levels of reporting by reducing | Develop Business Case to secure | Dir of N&G | March 2014 | Business Case | Complete |

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
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| | it takes staff to report incidents etc. on DATIX? | the amount of time it takes. | resource.<br><br>Change front end of DATIX. | | ~~March 2015~~ **October 2015** | approved.<br><br>New front end operational. | **New front end designed and modules reconfigured. Workplace testing and staff training commenced. Delays due to enhancing scope of new DATIX systems, operational processes and improving infrastructure further to staff feedback and baseline data analysis.** |
| **25** | **Board QGF self-assessment** Further improve and develop performance system with Clinical Governance policies. | Arrangements exist that incentivises individual and team performance. | Develop proposals. | Dir of HR | September 2014 | Recommend ations agreed by EMT | Draft Pay & Reward Policy Statement consultation to be completed March 2015. |
| **26** | **Board QGF self-assessment** Lack of "stop the line" methodology. | Reduction of harm. | To develop a "stop the line" methodology for implementation.<br><br>Implement agreed methodology. | Clinical Director/ KPO<br><br>CE | July 2014<br><br>March 2015 | | Stop the line methodology has been developed for use by Psychosis Teams and this is being rolled out, along with all other elements of the Model Line. |

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
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| 27 | **Board self-assessment**<br>Benchmarking. | To be able to put in perspective the "performance" of TEWV and learn from best in class. | Benchmark reports on:<br>• Use of MH Act<br>• Use of restraint<br>• Medication errors<br>• Use of inpatient beds | Dir of P&P | July 2015 | Reports considered by Board. | |
| 28 | **Board self-assessment**<br>CRES Schemes – their impact. | For the Board to know the impact of CRES schemes at the end of each year. | Annual Report to the Board.<br><br>Exception reports in-year if unintended consequences / greater impact than expected. | Dir of Fin<br><br>Dir of Fin | May 2015<br><br>May 2015 | Report to Board.<br><br>Report to Board. | **Complete**<br><br>**Complete** |
| 29 | **Board self-assessment**<br>Capital business cases to include a section on impact on patients. | Clarity on expected impact on patients of capital schemes. | All business cases to include explicit section on impact on patients. | Dir of Fin | wef 1 April 2015 | All capital scheme business cases presented to Investment Committee. | Ongoing |
| 30 | **Board self-assessment**<br>Improve communication and involvement with patients and develop new ways of understanding the expectations of patients. | The Trust can demonstrate good use of social media, our web site and user and carer networks to improve our understanding of the expectations of users and carers. | New web site.<br><br>Strengthen AMH user groups.<br><br>Increased volume of use of Twitter and Facebook. | Dir of Fin<br><br>Trust Sec<br><br>Dir of P&P | March 2016<br><br>March 2016<br><br>March 2016 | New web site operational.<br><br>New networks / groups operational.<br><br>Numbers. | |
| 31 | **Board self-assessment**<br>Improve communications regarding programmes of work | Staff understand why decisions are made. | When the Board and EMT make decisions the reason/s for those | Chief Exec | wef April 2015 | Metric to be determined. | |

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
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| | and systems by explaining why decisions are taken and email protocol. | Appropriate use of emails. | decisions is clear.<br><br>Develop new email protocol that makes it clear when telephone calls or face-to-face dialogue would be better. | Chief Exec | wef April 2015 | New email protocol published. | |
| **32** | **Board self-assessment**<br>Improve reporting of results of clinical audits and improve clarity on how action plans are developed and implemented. | | Reports to be produced by Clinical Directorate.<br><br>Action plans developed and implemented by Clinical Directorate. | Dir of N&G<br><br>Dir of N&G | July 2015<br><br>July 2015 | Reports to QuAC.<br><br>Action Plans by Clinical Directorate. | **Complete – New suites of reports in place.** |
| **33** | **Board self-assessment**<br>Establish Learning Sets to help spread learning from experience. | Accelerated spread of what works best and support to key staff. | Establish Learning Sets of people with same roles. | Chief Exec | December 2014 | Learning Sets in place. | Deferred due to capacity and doubts about feasibility. |
| **34** | **Board self-assessment**<br>Rationalise content on Dashboard. | Ensure consistency, coherence and relevance. | "5" S the Dashboards. | Dir of P&P | ~~June 2015~~ **September 2015** | Report to EMT / Board of outcome of "5" S | |
| **35** | **Board self-assessment**<br>To improve understanding of Risk Registers, etc. | Directorate Risks are appropriately identified, described and managed. | Training of Heads of Service and equivalent. | Trust Sec | Autumn 2015 | Training completed. Content of Risk Registers. Internal Audit Report. | |

**ITEM 18**

## FOR GENERAL RELEASE

## BOARD OF DIRECTORS

**Date of Meeting:** 23rd July 2015

**Title:** Policies and Procedures Ratified by the Executive Management Team

**Lead Director:** Martin Barkley, Chief Executive

**Report for:** Information

### This report includes/supports the following areas:

| STRATEGIC GOALS: | ✓ |
|---|---|
| To provide excellent services working with the individual users of our services and their carers to promote recovery and well being | ✓ |
| To continuously improve the quality and value of our work | ✓ |
| To recruit, develop and retain a skilled and motivated workforce | ✓ |
| To have effective partnerships with local, national and international organisations for the benefit of our communities | |
| To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities | ✓ |

| CQC REGISTRATION: Outcomes (✓) | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | ✓ | Consent to care and treatment | ✓ | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | ✓ | Cleanliness and infection control | ✓ | Management of medicines | ✓ |
| Safety and suitability of premises | ✓ | Safety, availability and suitability of equipment | ✓ | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | ✓ | Staffing | | Supporting workers | ✓ |
| **Quality and management** | | | | | |
| Statement of purpose | ✓ | Assessing and monitoring quality of service provision | ✓ | Complaints | ✓ |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | ✓ | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | ✓ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

**BOARD OF DIRECTORS**

**Date of Meeting:** **23rd July 2015**

**Title:** **Policies and Procedures Ratified by the Executive Management Team**

## 1. INTRODUCTION & PURPOSE

1.1 The purpose of this report is to advise the Board of Directors on the policies and procedures that have been ratified by the Executive Management Team.

## 2. BACKGROUND INFORMATION

2.1 Following the last revision of the Trust's Integrated Governance arrangements, it was agreed that the Executive Management Team ratify all new and revised Trust policies and procedures.

2.2 Each policy and procedure ratified by the Executive Management Team will have gone through the Trust's consultation process.

## 3. KEY ISSUES:

3.1 The following documents had their review date extended:

**CLIN-0012-v5 Admission and Discharge of Patients from Hospital and Residential Settings policy**
**CORP-0003-v7 CCTV Policy**
**CORP-0025-v6 Safe Haven Policy**
**CORP-0050-v2 Research Governance policy**
**STRAT-0001-v5 Records Management Lifecycle strategy**
**STRAT-0025-v1 Research and Development strategy**

Extension to 31 July 2015

**CORP-0007-v4 Data Protection Policy**
**CORP-0013-v3 Freedom of Information Act Policy**

Extension to 31 August 2015

**CORP-0008-v3 Medical Devices Management policy**

Extension to 31 October 2015

## 4. IMPLICATIONS / RISKS:

4.1 **Quality:**
Sound policy development improves patient experience and enhances patient safety and clinical effectiveness

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

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

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

4.5 **Other Risks:**
None Identified

## 5. CONCLUSIONS

The decisions detailed above made at the EMT meeting on 1 July 2015 have been presented for ratification.

## 6. RECOMMENDATIONS

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

**Martin Barkley**
**Chief Executive**