AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS THURSDAY 20th JULY 2017
VENUE: THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON
AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	Declarations of Interest.		
Item 2	Chairman's Report.	**Chairman**	**Verbal**
Item 3	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.40 am)

Item 4	To receive the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 5	To consider the six monthly Nurse Staffing Report.	**EM**	**Attached**
Item 6	To receive and note a report on the Trust's position against the Stirling Dementia Design Guidelines.	**BK**	**Attached**
Item 7	To receive and note a progress report on actions taken to address waiting times in Child and Adolescent Mental Health Services.	**BK**	**Attached**
Item 8	To consider a report on the TEWV Way Business Plan priority.	**BK/DL**	**Attached**
Item 9	To receive and note the annual report on Directors' visits.	**BK**	**Attached**

Performance (11.20 am)

Item 10	To consider the summary Finance Report as at 30th June 2017.	**DK**	**Attached**
Item 11	To consider the Trust Workforce Report as at 30th June 2017.	**DL**	**Attached**

*(**Note:** The Performance Dashboard Report will be circulated to Board Members separate from the meeting).*

Governance (11.40 am)

Item 12	To consider a report on the Trust's position against the Single Oversight Framework.	**PB/SP**	**Attached**
Item 13	On the recommendation of the Quality Assurance Committee to approve the Trust's Workforce Race Equality Standard Action Plan.	**DL**	**Attached**
Item 14	To consider a progress report on the York and Selby Quality Governance Action Plan.	**PB**	**Attached**
Item 15	To receive a report on the results of the Board Performance Evaluation Scheme 2016/17.	**PB**	**Attached**

Items for Information (12.00 noon)

Item 16	To receive and note a report on the use of the Trust's seal.	**CM**	**Attached**
Item 17	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 18 To note that the next meeting of the Board of Directors will be held on Tuesday **26th September 2017** in the Board Room, West Park Hospital Darlington at 9.30 am.

Confidential Motion (12.05 pm)

Item 19 **The Chairman to move:**

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

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

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

Information which, if published would, or be likely to, inhibit -
(a) the free and frank provision of advice, or
(b) the free and frank exchange of views for the purposes of deliberation, or

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

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

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
14th July 2017

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

ITEM 4

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 20 July 2017**
TITLE:	**To receive the assurance report of the Quality Assurance Committee**
REPORT OF:	**Dr Hugh Griffiths, Chairman, Quality Assurance Committee**
REPORT FOR:	**Assurance**

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

Executive Summary:

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

Assurance statement pertaining to QuAC meeting held on 06 July 2017:

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

Key matters considered by the Committee are summarised as follows:

- The Locality areas of Tees and Durham and Darlington where key concerns were around estate, transforming care, recruitment and staffing and capacity and demand. Matters of escalation noted by QuAC included problems with Blik alarms at Roseberry Park and the impact of a high proportion of newly qualified nurses in inpatient areas.
- An update from the Patient Safety Group, following its meeting held on 19 June 2017.
- Medicines optimisation Annual Report and Medicines Management Assessment Report.
- CQC compliance and Safeguarding & Public Protection assurance updates.

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 06 July 2017.
- Note the confirmed minutes of the meeting held on 01 June 2017 (appendix 1).

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 20 July 2017**
TITLE:	**To receive the assurance report of the Quality Assurance Committee**

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting on 06 July 2017.

2. BACKGROUND INFORMATION AND CONTEXT

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

3. KEY ISSUES

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

4. QUALITY ASSURANCE - EXCEPTIONS/ASSURANCE REPORTS FROM THE LOCALITY MANAGEMENT GOVERNANCE BOARDS (LMGBS) AND SUB-GROUPS OF THE COMMITTEE

The Committee received key assurance and exception reports from LMGBs and standing Sub-Groups of the Committee, highlighting any risks and concerns.

4.1 TEES LMGB

The Committee received the LMGB report for Tees noting the ongoing concerns around medical recruitment, Transforming Care in LD and lack of capacity and quality of Nursing Homes in MHSOP.

The Committee noted matters of escalation from Tees LMGB which were ongoing problems with Blik alarms at Roseberry Park and the time taken to replace alarms that were not working.

Also, the impact on inpatient areas of the high proportion of newly qualified nurses versus more experienced staff.

4.2 DURHAM & DARLINGTON LMGB

The Committee received the LMGB report for Durham and Darlington noting the top concerns which were:
A never event on Willow Ward, when there was no night shift cover from a Registered Nurse. This was being investigated and mitigating actions had been taken to reinforce due process on wards around staffing and timely and appropriate escalation of any issues.
NHS Intensive Support Team (IST) visit to Talking Changes IAPT.

There were lots of positive messages in terms of clinical leadership, and supervision models, however the IST feel that the 15 % prevalence target could be stretched to 16.8% and this would be a challenge.

Very long waiting times for children with autism where the longest wait was 151 weeks in North Durham.

The Committee recognised the complexities around the long care pathway for diagnosing autism and families were being informed by letter on what was available to them while they wait.

4.4 **Patient Safety Group Report**

The Patient Safety Group had met on 19 June 2017 and reviewed all Trust Patient Safety activities in line with the Group's terms of reference.

There were no matters of escalation to the Quality Assurance Committee.

The Committee noted the Patient Safety Quality Report for the period 1 to 30 April 2017.

The Committee discussed the NEMHDU thematic review of 15 serious incidents relating to patients on leave during the period February 2015 to October 2016.

An action plan based on the seven recommendations set out in the report would be monitored by the Patient Safety Group and would also be sent to the Coroner.

4.6 **Safeguarding and Public Protection Report**

The Committee was assured that the Trust continues to meet the legal requirements for safeguarding adults and children within the legislative framework.

All serious case reviews across the locality areas were progressing with action plans being monitored within respective safeguarding boards with oversight by the Safeguarding and Public Protection sub-Group. There have been some lessons coming out of these reviews for the Trust which will be actioned.

The Committee sought further assurance around compliance with safeguarding training, levels two and three, where progress within localities has been slow. Further information will be presented to the 7 September 2017 Quality Assurance Committee meeting.

5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

5.1 **Compliance with CQC Requirements Report**

The Committee noted the Compliance with CQC Requirements Report.

Assurance was provided that the Quality Compliance Group have drafted a programme of peer review visits from July 2017 – June 2018, which would be led by ward managers and clinical leads.

All actions raised by CQC Mental Health Act inspections were being addressed following three reports for Nightingale, Jay and Kirkdale wards.

Some deadlines for the completion of the Trust wide actions following the CQC Compliance Visits have been discussed with the CQC lead inspector and will be brought forward from the original deadline of 31 March 2018.

5.2 **Medicines Optimisation Annual Report 2016/17**

The Committee received the first Annual Report on Medicines Optimisation for 2016/17.

The report covered themes such as medicines safety, prescribing governance, minimising waste, developing clinical pharmacy services and workforce development.

The report provided assurance on the joint working by the Drug & Therapeutics Committee and the medicine optimisation initiatives led by the pharmacy team working strategically towards a 5 year vision.

The Committee welcomed the concise style of the annual report and noted the progress being made against the various initiatives.

5.3 **Medicines Management Assessment (MMA) - Progress Report**

The Committee noted the progress report on the medicines management assessments, which have been running for 6 months.

Assurance was provided to the Committee that there have been improvements in all ten standards across all wards, including security of stationary and medicines, which has improved to 99% in June 2017 and security of medicines cupboards and fridges up to 97%.

6. IMPLICATIONS

6.1 **Quality**

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

6.2 **Financial/value for money**

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

6.3 **Legal and Constitutional (including the NHS Constitution)**

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

6.4 **Equality and Diversity**

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

7. CONCLUSIONS

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

8. RECOMMENDATIONS

That the Board of Directors:

(1) Note the issues raised at the Quality Assurance Committee meeting on 06 July 2017 and to note the confirmed minutes of the meeting held on 01 June 2017 (appendix 1).

Jennifer Illingworth
Director of Quality Governance
20 July 2017

APPENDIX 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 1 JUNE 2017, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mrs Lesley Bessant, Chairman of the Trust
Mr Jim Tucker, (Deputy Chairman of the Trust)
Mrs Jennifer Illingworth, Director of Quality Governance
Dr Nick Land, Medical Director
Mr Colin Martin, Chief Executive
Mr David Jennings, Non-Executive Director
Mr Richard Simpson, Non-Executive Director
Mrs Shirley Richardson, Non-Executive Director

In attendance:
Mrs Karen Agar, Associate Director of Nursing & Governance
Mr Levi Buckley, Director of Operations for Forensic Services
Mrs Helen Cunningham, Health & Safety Manager
Mr Darren Gargan, Head of Nursing, Adult MH and Substance Misuse
Dr Ahmad Khouja, Clinical Director, Forensic Services
Mr Mark Fletcher, Associate Director, Grant Thornton UK
Ms Donna Oliver, Deputy Trust Secretary
Mrs Ruth Hill, Director of Operations for York & Selby
Mr David Levy, Director of Human Resources and Organisational Development
Professor Joe Reilly, Clinical Director
Mr Stephen Scorer, Deputy Director of Nursing
Mrs Rachel Weddle, Head of Nursing for Forensic Services
Mr Christopher Williams, Chief Pharmacist

Student Nurses from the University of Teesside.

17/73 APOLOGIES FOR ABSENCE

Apologies for absence were received from, Mrs Elizabeth Moody, Director of Nursing & Governance, Mr Brent Kilmurray, Chief Operating Officer and Mrs L Parsons, Associate Director of Operational Services.

17/74 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 4 May 2017 be signed as a correct record by the Acting Chairman of the Committee.

17/75 ACTION LOG

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

17/42 Log with complaints Department the issue of PALS and complaints coming from MPs regarding York & Selby, which need to be recorded.

Mrs Illingworth reported that this matter had been followed up.

Completed

17/60 Discussion required at EMT around housekeeping and levels of cleanliness in the York & Selby facilities.
This matter would be deferred to the July QuAC meeting.

17/63 Self Harm Report – check accuracy of statistics, "4-70% of people self-harm during an inpatient admission".
Mrs Illingworth reported that this had been a typographical error.

Completed

17/21 Deeper analysis of Mallard and Clover around the cancellation of patient leave.

Mr Buckley gave an update on the current measures being used to monitor leave on a quarterly basis.

The Committee asked for consideration to be given to an audit across the Forensic service to identify the incidents of leave cancelled for individual patients.

Mr Buckley undertook to consider within the team how best to take this forward and report back to QuAC in the next Forensic LMGB report in September 2017.

Action: Mr L Buckley

17/21 C) Issue relating to staff safety in offender health (Page 9) to be followed up. Is there a solution to this?

This matter remained outstanding. Mr Buckley would look into any known timescales for the introduction of a 'safe room', for the segregation of particularly aggressive individuals referred from the offender health service and would report back in the next Forensic LMGB report in September 2017.

Action: Mr L Buckley

17/76 FORENSIC SERVICES LMGB REPORT

The Committee received and noted the Forensic Services LMGB Report.

Arising from the report it was highlighted that the top concerns at present were:

(1) Estates and security issues.
Following a security incident in February 2017 an independent review of security had been undertaken and an action plan would be submitted to the June LMGB meeting.

(2) Transforming care.
Further requirements from NHS England to reduce Adult and Forensic LD beds still lacked transparency due to no final agreement around the numbers of beds to be decreased and the decision making process.

(3) Staffing
Recruiting suitably qualified and experienced staff remained a challenge as well as pressure recruiting psychologists and AHPs.
On this matter it was noted that there were some joint recruitment events planned, a project around rostering and some work on the retention of staff with exit interviews.

Non-Executive Directors sought clarification on the following matters:

(1) Offender health - where educational courses had taken priority over health care appointments.
Mr Buckley advised that the prisons received payment for inmates undertaking courses and that this sometimes took precedence over health care appointments. It had however been raised as a concern with Durham Prison.

(2) The two hour programme around alternative injection sites.
On this matter it was noted that this training programme would be rolled out Trust wide and drop in sessions would also be available with the aim to reduce the use of prone restraint.

(3) Concern raised over the lack of attendance at the Recovery College and service users not liking the term 'College'.

Mr Buckley noted that forensic patients would soon be able to access the virtual Recovery College and there would be courses on the ward to include an explanation around the terminology 'Recovery College' to dispel future concerns.

17/77 YORK & SELBY LMGB REPORT

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

Arising from the report it was highlighted that the top concerns at present were:

(1) The level of Management of Change and the impact on staff.
(2) Capacity and demand issues with ongoing issues around CAMHS services.
On this matter it was noted that significant waiting list issues continued and the service was working with the Business Planning team to complete a capacity and demand review. The review had highlighted significant staffing level gaps in all of the clinical pathways and a model of staffing level requirements to clear the waiting lists had been worked through.

The locality could not release funding to address the staffing gaps at present and discussions with Commissioners around the next steps would need to take place.

***Agreed** – to escalate to the Board of Directors the pressures around capacity and demand in CAMHS services.*

Action: Mr B Kilmurray

(3) Staffing and gaps in the workforce, with unsuccessful medical recruitment recently and no further applications. A review of the recruitment strategy was underway and locum staff were covering the current shortfall.

17/78 ANNUAL PATIENT SAFETY REPORT 2016/17 & LEARNING FROM SERIOUS INCIDENTS REPORT

The Committee received and noted the Annual Patient Safety Report for 2016/17 and Learning from Serious Incidents Report.

In introducing the report Mrs Illingworth reported that:

1. The report provided a look back over 2016/17 with regard to incident reporting and associated patient safety activities.

2. A total of 21,196 incidents had been reported via Datix, which was an increase of 5,438 from 2015/16. Some of this increase related to the first full year of York & Selby reporting.
3. Teesside had reported the highest number of incidents at 6,179, followed by North Yorkshire with 4,239 incidents. This was due to the Teesside locality having the most inpatient beds (263).
4. The report included a new category of 'expected death'.
5. North Yorkshire reported the highest number of incidents at 34, followed by Durham and Darlington.
6. Part 2 of the report detailed the learning from incidents and those that had been to Directors panels.

Assurance was provided to the committee that there were robust processes and monitoring in place around learning from incidents where the root cause or contributory factors would be examined and actions taken to address matters.

Following discussion it was noted that a review of the root causes in the system at ground level where incidents had occurred would enable better learning from incidents.

17/79 PATIENT SAFETY GROUP REPORT AND PATIENT SAFETY QUALITY REPORT FOR PEROID 1 - 31 MARCH 2017

The Committee received and noted the report of the Patient Safety Group and the Patient Safety Group Quality Report for March 2017.

Arising from the report it was highlighted that:

(1) The Patient Safety Group had met on 15 May 2017 and reviewed all Trust Patient Safety activities in line with the Group's terms of reference.
(2) The restrictive practice policy had been reviewed and agreed.
(3) The Group had been presented with two completed structured case reviews, one of which raised some concerns regarding access to psychology services.
(4) As a result of the new Learning from Deaths guidance the Trust would be required to publish data in relation to deaths of service users quarterly.

17/80 PATIENT EXPERIENCE GROUP REPORT (PEG)

The Committee received and noted the Patient Experience Group report (PEG).

Arising from the report it was noted that:

1. The Patient Experience Group had met on 11 April and 9 May 2017 to provide assurance regarding compliance with the CQC Fundamental Standards in respect of Regulation 16 – Receiving and acting on Complaints and Regulation 17 – Good Governance where the requirement is to seek and act on feedback from service users and carers on the services provided.
2. Concerns had been raised over representation from the localities at the Patient Experience Group meetings, with difficulties for all locality representatives to be present at each monthly meeting.

   The Committee considered whether the PEG should meet bi-monthly and this would be taken back to the next meeting for discussion, together with a general review of the Group.

Action: Dr I Whitton/Mrs J Illingworth

17/81 SAFEGUARDING & PUBLIC PROTECTION REPORT

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

Mrs Agar highlighted the following matters:

1. The Safeguarding Adult teams had undergone organisational change in order to standardise the team structures, which would enable more joint working.
2. There had been three CQC Safeguarding Children reviews for looked after children in Durham, York and North Yorkshire, which had led to the development of a Trust wide action plan.
3. There was now a hub base for the Safeguarding team in York at Cherry Trees Hospital, which had enabled an influential safeguarding presence in York.
4. Development work had been undertaken on the recording of safeguarding information on PARIS.
5. Concerns had been raised by Commissioners around the safeguarding children level three compliance. The uptake around this training had been variable and would be monitored closely.

   Assurance was provided to the Committee that collaborative working between Human Resources, operations and governance was being undertaken to mitigate against the risk of failing to meet the trajectories for Safeguarding Children Level three training.

   Mrs Agar undertook to check whether staff in HM Prisons also required this training.

   Action: Mrs K Agar

6. There had been an increase in the number of MAPPAs the Trust had been invited to and work was underway with the MAPPA coordinators to ensure appropriate TEWV representation.

17/82 RESEARCH GOVERNANCE GROUP REPORT

The Committee received and noted the Research Governance Report.

Professor Reilly highlighted the following matters:

(1) Audit One had conducted an internal audit of the effectiveness of controls over research activity undertaken by the Trust, which had revealed a good level of assurance and that risks were being managed effectively.
On this matter it was noted that this was the first time that Audit One had undertaken such an audit of research and development processes and the audit would be repeated in three years' time.

(2) The first Research Awareness Course at the ARCH Recovery College had been co-delivered by the research team and service user with research experience, which had been well received. A further course would take place in June 2017.

17/83 DRUG & THERAPEUTICS REPORT

The Committee received and noted the Drug & Therapeutics Report.

Arising from the report it was noted that:

(1) The Drug & Therapeutics Committee had met on 25 May 2017 and assurance was provided to the Quality Assurance Committee on the medicine management documents approved.
(2) Regarding medicines safety urine drug testing kits - "Home Health One Step Drug of Abuse" tests had been supported, which would detect the use of various drugs in urine and this would be the only available test available to procure on Cardea.
(3) Four audits had been seen by the Group with action plans in place against the outcomes.

17/84 WORKFORCE AND STAFFING REPORT

The Committee received and noted the Workforce and Staffing Report.

Mr Levy drew attention to the following matters:

1. The report contained the latest available workforce Race Equality Standard information and an update on progress against the action plan.
2. An explanation was given around the indicators in Appendix One – TEWV WRES information.
3. With regard to indicator five – the percentage of staff experiencing bullying and harassment or abuse from patients, relatives or the public in the last 12 months had increased for both BAME and white staff from 27% and 20% to 37% and 28%.

   On this matter Mr Levy advised that there was some further work to do around this indicator before the report was presented to the July Board of Directors to ensure that this was being looked at in a targeted way.

Action: Mr D Levy

Recommended to the Board of Directors that, subject to the caveat around indicator five, the action plan supporting workforce Race Equality Standards be approved.

17/85 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS REPORT

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

Arising from the report it was noted that:

(1) The Quality Compliance Group had met twice to monitor the CQC action plan and to prevent the repeat actions following MHA inspections.
Mock inspections would be led by operational services, rather than corporate services as a quality/peer review and a new monitoring tool would be used which would be more interactive and responsive for services to use.

Mr Simpson welcomed the work of the Quality Compliance Group, especially in order to prevent repeated issues being picked up on MHA inspections, which had also been reported through to the Mental Health Legislation Committee.

(2) Final reports had been received following the CQC inspection of the Trust in January 2017, where the Trust had maintained a 'good' position.

17/86 HEALTH, SAFETY, SECURITY AND FIRE GROUP REPORT

The Committee received and noted the Health, Safety, Security & Fire Group Report.

Mrs Cunningham highlighted the following matters:

1. There had been a significant increase in physical assaults against Trust staff and the data would be reviewed to ensure that the incidents met the NHS protect criteria and would be taken to the 6 July 2017 Health, Safety, Security and Fire Group for consideration.
2. Fire incidents reported during 2016/17 had increased from 73 to 255 since 2015/16. On this matter it was noted that 55 of these incidents had occurred inside premises.

Mr Griffiths requested that future reports identify the fire incidents broken down by Hospital location.

Action: Mrs L Parsons

17/87 QuAC ANNUAL PERFORMANCE ASSESSMENT RESULTS 2016/17

The Committee received and noted the annual performance assessment results for 2016/17.

Overall the Committee had improved on all areas, except communication between QuAC and LMGBs and its assurance groups.

Dr Griffiths suggested that Committee review the relationship between QuAC and LMGBs, following on from the work that was undertaken 18 months ago.

Agreed – *that a representative group of QuAC members and LMGB leads meet to look at further improvements around providing assurance to the Committee.*

Action: Ms Oliver

17/88 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no exceptions to report.

17/89 ANY MATTERS ARISING TO BE ESCALATED TO THE BOARD OF DIRECTORS OR PROPOSED FOR ADDITION TO THE TRUST RISK REGISTER, AUDIT COMMITTEE, RESOURCES COMMITTEE OR CLINICAL LEADERSHIP BOARD.

That the matter of pressures on capacity and demand in CAMHS be escalated to the Board.

17/90 ANY OTHER BUSINESS

There was no other business to note.

17/91 COMMITTEE MEETING EVALUATION

There was nothing to note.

17/92 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 6 July 2017, 2.00pm – 5.00pm in the Board Room, West Park Hospital.
Email papers/reports to Donna Oliver donnaoliver1@nhs.net

ITEM 5

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**20th July 2017**
TITLE:	**To consider the "Hard Truths" 6 monthly Nurse Staffing Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

The purpose of the report is to advise the Board of a 6 monthly review (1st December 2016 to 31st May 2017) of in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review) and in line with the NQB Guidance.

A safer staffing steering group has been established to oversee a work plan to ensure the Trust has robust systems and processes in place to assure them that there is sufficient capacity and capability to provide high quality care to patients. Safe Staffing is one of the strategic business priorities for the trust board and a safe staffing programme manager has now been appointed to manage this strand of work. They will commence in post in August 2017.

In conclusion, the following is of relevance:

- Evidence based establishment reviews have been undertaken for all mental health inpatient wards across the Trust with all data collected. This is currently being progressed through the Hurst Tools. Professional judgement meetings are ongoing and will conclude by the end of August 2017.
- Roster reviews have completed across all inpatient areas (excluding York and Selby). Awaiting final report which will be presented to OMT.
- Changes to numbers of staff in post can be observed as follows:
  - Durham & Darlington - overall increase of registered nurses and a reduction of unregistered nurses is evident. Additional staff in post is evident in Birch and Tunstall wards. Reduction in both registered and unregistered staffing within Primrose Lodge is evident.
  - A reduction of both registered and un-registered nurses in Forensic Services is evident and linked to the reduction of beds as part of the transforming care agenda. A reduction of staff in post is also evident within FMH.

- North Yorkshire a reduction of registered nurses is observed and relates to Danby Ward and Cedar (NY).
- Within Teesside a reduction of registered and un-registered nurses has been observed and is linked to roster changes around Bankfields Court.
- An increase in registered nurses can be observed within York and Selby.

- In line with 'NQB guidance for Right Skills', the paper sets out a number of development programmes in place to enhance the skills of our workforce.

- Regarding staffing activity, the 6 month average shows:
  - The actual hours worked exceeding the planned hours across all months. All metrics are reporting above the 89.9% tolerance.
  - Primrose Lodge as having the lowest fill rate for registered nurses on days and relates to sickness and vacancies. The use of HCA's to backfill some of the registered nurses is evident.
  - Springwood and the Orchards were cited as having the second lowest fill rate. Springwood was in relation to registered nurses on days as a result of vacancies whilst the Orchards was in relation to unregistered nurses on days and relates to long term sickness and vacancies.
  - Sickness is the biggest factor impacting on staffing with 44 wards (this is a reduction on the previous 6 months whereby 48 wards reported sickness as the biggest impact). Maternity Leave (22 wards) and bank usage (9 wards) were cited as the second and third highest.
  - 8,727 additional duties were created with a reason of 'enhanced observations'. This is an increase of 6 duties when compared to the previous 6 month report. The 8,727 additional duties created equate to 94,255 hours an increase of 5,505 hours when compared to the previous 6 month period. This would suggest that the lengths of the shifts being created are increasing in hours.
  - Merlin Ward was cited as the highest users of additional duties with a reason of 'enhanced observations'.
  - Bank usage greater than 25% equating to 9 wards in 3 separate localities. Westerdale South had the highest with a bank usage of 37.6%
  - Agency usage relating to 13 wards in 3 separate localities. Acomb Garth had the highest with an agency usage rate of 34.7%.
  - All wards are using overtime to fill shifts however, those in excess of 4% equates to 31 wards. Teesside are using the most overtime whilst York and Selby are using the least.
  - There are 13 wards from 3 separate localities that have utilised bank, agency and overtime within the reporting period.

- Triangulation of quality data over the 6 month average:
  - 74 incidents rose during the reporting period citing concerns with staffing levels. This is a decrease of 47 when compared to the previous 6 month report (121 incidents raised).
  - Incident raised whereby there was no registered nurse on duty was highlighted on the 31st May in relation to Willow Ward.
  - Triangulation of SIs, level 4 incidents, level 3 self-harm, complaints and incidents control and restraint with bank usage and the fill rates did not highlight any correlations between these strands of data.
  - Triangulation of falls that have resulted in significant harm, pressure ulcers, medication errors, breaks not taken, with that of bank usage and the fill rate indicators. From this it is not possible to draw any meaningful conclusions from this data for the period of this report.
  - In terms of patient, staff and carer feedback an analysis of the data from complaints, friends and family test and compliments has been undertaken but there were no specific issues raised with regards to staffing levels.

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

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**20th July 2017**
TITLE:	**To consider the "Hard Truths" 6 monthly Nurse Staffing Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of a 6 monthly review (1st December 2016 to 31st May 2017) in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review) following the format of the new NQB 2016 Guidance.

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013) are for NHS providers to address specific recommendations about nursing staff. The Trust has met these directives as required including the publication of this report and a dedicated web page on nurse staffing. (http://www.tewv.nhs.uk/site/content/About/How-well-are-we-doing/Nurse-staffing). The full monthly data set of day by day staffing for each of the 73 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

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

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

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

2.5 There is a national work stream looking at service specific guidance, recently this has included the draft publication of Learning Disability and Mental Health specific guidance. The guidance has been considered within the trust safe staffing work stream as part of the professional judgement approach in relation to the establishment reviews.

2.6 Safe Staffing is one of the strategic business priorities for the trust Board, accordingly the Executive Management Team have approved a Safer Staffing Programme that will manage

the implementation of the NQB guidance. A programme manager has been appointed and will commence in post in August 2017.

3.0 TRIANGULATED APPROACH TO STAFFING DECISIONS:

3.1 Right Staff

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

3.1.2 The Trust is progressing with the implementation of the Hurst Tool and the mental health multiplier in order to review the current staffing establishments within inpatient areas (excluding Learning Disabilities – awaiting final guidance). All of the data collection has concluded with this information being progressed through the Hurst Tool. In addition professional judgement meetings have and will continue with the remainder of the inpatient areas (appendix1 shows a copy of the proforma used during the professional judgement meetings). Once completed this information will be collated along with the output from the Hurst Tools to form recommendations on the nursing staffing establishments. It is anticipated that the initial draft of this work will be concluded by the end of August 2017. This work is integral to not only ensure compliance with the national requirements but will ensure that the staffing establishments and skill mix in place are appropriate based on the acuity and complexity of our patients as well as enhancing the quality of care by ensuring that our resources are deployed effectively and efficiently across the inpatient areas. A report of the establishment review findings will be presented for discussion and agreement to the board once this process has concluded.It is anticipated that this will be in October 2017.

3.1.3 As an interim approach the budgeted staffing establishments as at 1st December 2016 and the 31st May 2016 have been obtained from HealthRoster and have been used to compare the actual establishments in post. Attached at appendix 2 of this report is the full breakdown by ward and locality. The key points are as follows:

- Durham & Darlington – registered nurses in post has increased by 2.90 WTE and a reduction of 1.30 WTE unregistered nurses can be observed across the locality. It is evident that Birch Ward have seen an increase in both registered (4.8 WTE) and unregistered (3 WTE) staffing. Primrose Lodge have seen a reduction in both registered (2 WTE) and unregistered (3 WTE) staff. Tunstall ward have an increase of 3 WTE registered nurses in post.
- Forensic Services – registered nurses in post has reduced by 9.10 WTE and a reduction of 24.20 WTE for unregistered nurses. 19.5 WTE (8 registered nurses and 11.5 unregistered nurses) were in relation to Forensic LD and the reduction of beds linked to the Transforming Care Agenda. In terms of Forensic MH, Sandpiper has 1.5 WTE less registered nurses in post and 3.4 WTE unregistered nurses in post. This is a similar

picture in relation to Swift Ward whereby a reduction can be observed in relation to registered nurses (1 WTE) and a reduction of 2.60 WTE unregistered nurses in post. Linnet Ward has 2 additional registered nurses in post and the budgeted establishment has increased by 2 WTE in relation to unregistered nurses. An additional 2 WTE registered nurses in post can be observed with regards to Newtondale Ward.

- North Yorkshire – registered nurses in post has reduced by 0.6 WTE and 8.3 WTE less unregistered nurses. Danby Ward has 2.20 WTE less unregistered staff in post in May when compared to December. Ward 15 has been cited with 2 WTE less registered and unregistered nurses in May when compared to December. In addition Cedar (NY) has also been cited as having 2 WTE less unregistered staff in May. Rowan Ward has seen an increase of 2 WTE in their budgeted establishment for unregistered staff.
- Teesside – registered nurses in post has reduced by 15.8 WTE and 0.6 WTE less unregistered nurses. Stockdale Ward has been cited as having 2.3 WTE more unregistered staff in post in May when compared to December. Lincoln and Lustrum Vale have been cited as having 2.5 WTE less registered nurses in post in May. The Evergreen Centre have been cited as having 2.1 WTE less registered nurses and 3.8 WTE additional unregistered nurses in post in May when compared to December. The Westwood Centre has 1.4 WTE less registered nurses in post in May and 2.0 WTE additional unregistered posts when compared to December. A large reduction can also be observed with regards to Bankfields Court (7.3 WTE registered nurses and 9.30 WTE unregistered nurses); this is attributable to the roster being separated out for each individual ward area as opposed to have 1 overarching roster and also linked to the transforming care agenda.
- York and Selby – registered nurses in post have increased by 6.7 WTE and a reduction of 0.3 WTE unregistered nurses is also visible across the service. The closure of Worsley Court has been offset by the introduction of Acomb Garth.
- Across inpatient areas, this has resulted in a reduction in approximately 35 unregistered nurses however the total registered nurses in post has not changed significantly with the biggest impact being seen in Tees locality.

3.2 Right Skills

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

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

3.2.3 There are 5 wards within the Trust who in May 2017 are reporting less than 75% compliance for mandatory training as follows:

WARD	May
Maple Ward	68.77%
Elm Ward	74.73%
Clover/Ivy	69.23%
Rowan Ward	74.09%
Ebor Ward	73.88%

3.2.4 There has been considerable change in the world of nurse education and professional nursing roles in recent times, some of which has yet to fully work its way through. This section outlines some of the approaches the Trust either has taken or is developing in response to this emerging picture, while a longer term strategy is developed and the external national guidance continues to refine. The Trust also operates a number of development programmes to enhance the skills of our workforce. A key focus within our approach is to enhance the relationships with the local Higher Education Institutes, and diversify the range of training options at a time when external interest in registered nurse training appears to be declining and there are recruitment difficulties. The Trust is investing directly in both the development of new roles and maintenance of existing programmes. We are also seeking to provide greater support to our existing workforce to recognise the apparent increasing ratio of less experienced nurses within our in-patient establishments, which is under review, and to help to retain existing colleagues within the Trust. Some examples of the range of approaches are set out below:

- **Framework for inpatient HealthCare Assistants** - All new starters from April 2012 have been recruited utilising the HCA Framework and options were presented to existing staff. A database of all Trainee HCA's and the existing HCA workforce is held by the Workforce Department and collates all of the training activity. This approach is a key ingredient in preparing potential candidates for further professional training in line with some of the initiatives below, in addition to its own intrinsic value in staff development and patient care.

- **Nursing Associate Band 4 roles** - These new roles will in future be regulated by the Nursing and Midwifery council, as a new member of the nursing family. The Trust is currently part of a consortium of north east health care organisations which are piloting the role, as part of a national "fast-followers" approach. The organisation agreed to enable ten staff to take up these roles, (there are 92 places across the North-East locality). Minimal costs relating to training are being met by Heath Education England. The academic component of the training is at foundation degree level and delivered by Teesside University. The Trust has made a financial commitment of £186,000 to meet the associated backfill costs in delivering this programme. Nursing Associates will be expected to work alongside care assistants and registered nurses to deliver hands-on care, focusing on ensuring patients continue to get the compassionate care they deserve. Its introduction has the potential to transform the nursing and care workforce - with clear entry and career progression points and we will need to develop a workforce plan to reflect where the new colleagues sit within future service development and

indeed the safe staffing returns. The nursing associates were appointed in TEWV following a rigorous application and interview process. The trainees started a two week induction at Teesside University on 24th April along with the trainees from all service providers across the North East. The programme will be forty five weeks per year for two years. Trainee Nursing Associates will be employed in one of three health and/or care settings – defined as; in hospital, Close to home, and at home. As such there is intended to be good transferability of skills and potential for placements in partner organisations, as befitting of a regulated role, and which sets the role apart from the earlier approaches to developing band 4 associate practitioners.

- **Apprenticeship Pre-Registration Training** - The apprenticeship route into nurse training is now approved nationally at level 6. Locally we are engaging with Sunderland University, who are a relatively new entrant into the pre-registration field for us and are the approved local pilot provider of nursing apprenticeships. This forms part of our approach to diversify the range of training providers to attract the widest range of candidates of different backgrounds, and in particular to increase the number of our existing care staff who we can develop into registered nurses. It is likely the other local Universities will develop their own apprenticeship approaches shortly. This will bring opportunities to 'grow our own' workforce and potentially to recoup some of the apprenticeship levy.

- **Diversifying the range of training providers** - As noted above, we are actively seeking to extend our partnerships with local Higher Education Institutes, this includes: Sunderland on new apprenticeship approaches to nurse training.

  The Open University, or directly on to the OU pre-registration training programme- this enables colleagues to remain in work while studying as a distance learning model (and demonstrates a high degree of commitment in doing so). This brings some financial benefits to the Trust as well as allowing a more flexible approach to training which suits some colleague's circumstances.

  Coventry University, who are currently developing and adult nursing branch at their new campus in Scarborough, and are interested in potentially extending this into a mental health cohort from 2018.

- **Out of Hours nursing support – the Duty Nurse Co-ordinator** - A recent RPIW has been held to address the variation in support out-of-hours with the aim of increasing clinical (nursing) on-site support at these times. It was apparent that there could be non-clinical chain of command within the on-call processes and a degree of unwarranted variation in the clinical support models offered to inpatient services. A number of informal support mechanisms are operating at a local level as a result. The RPIW advocated the development of a Duty Nurse Co-ordinator role at key locations across the Trust, supporting the main hospital sites and the surrounding satellite units. It is proposed that this is drawn from the existing range of band 7 Ward Managers and Modern Matrons (who would come off the on-call rota to be on-site) during weekdays unti 8pm and 8am-8pm at weekends. This would also see the development of band 6

Duty Nurse Co-ordinators for the overnight period (the latter resembling the current model developed within forensic services). If approved, this would require the recruitment of a number of additional band 6 posts across the Trust nursing workforce, however these posts would enhance the safe staffing return for the organisation in line with the anticipated findings from the forthcoming establishment reviews. The proposals are to be taken to EMT for approval as a business case in July 2017.

- **Support for Learning Disability Nurse training** - We are aware that both of the two main Higher Education Institutes in the area, Teesside University and York University, are receiving very low numbers of student nurse applications for Learning Disability training, which is threatening the viability of the training courses in both cases. It is likely that the Universities will struggle to run their next cohorts, and this will have implications for future years as education infrastructure could be diverted elsewhere. The Trust remains a major employer of learning disability nurses despite the service re-modelling underway. It is possible that changes to the funding of nurse training (the introduction of student loans) and the current reviews of the future learning disability model nationally may have impacted disproportionately on this specific group of trainees, who have tended to be a small cohort of more mature students, often with existing loans from a first degree. A proposal has been approved by EMT recently, to directly support a small cohort of up to ten suitable internal candidates to take up Learning Disability Nurse training at the local HEI's. This will enable the local courses to be maintained while a strategic approach based around developing shorter approved courses is pursued. The Universities are working on marketing and clearing approaches simultaneously with this. This represents a considerable investment by the Trust in securing the future pipeline of registered nurses at an uncertain time in the education market. The details are being worked through with the finance department but currently represent around £800,000 of investment for the three year programme

- **Preceptorship** - Preceptor preparation workshops are delivered across the Trust to support preceptors in this role. Each preceptee has a specific work based developmental programme that follows a continuum of the four key task areas from the pre-registration programme. The retention of newly qualified staff is of growing importance within the organisation as there is a reportedly a less experienced body of nurses within inpatient services overall due to recruitment patterns and opportunities for promotion within community services. This is currently being explored further to fully understand the evidence relating to this widely reported problem. In addition to a focus on good quality preceptorship programmes, we are also seeking to increase the depth and quality of out of hours clinical support we are providing our nurses, as covered in the point above to aid retention.

- **Band 7/Ward Manager Development days** - Bi-monthly development days have continued to ensure that the Ward Managers are receiving appropriate development, networking and information sharing from the Board and other external bodies. These meetings are led by the Director of Nursing and Governance and provide peer support and reflective practice space for learning from each other's incidents and good practice.

The development days are attended by Heads of Nursing and this is combined with the bi-monthly Modern Matron forum on a 6 monthly basis.

- **Nursing Conference** – This year's nursing conference will be held on September 18th 2017, and will feature our shared and co-produced approach to Patient Safety as its key theme. A workshop on safe staffing will be included within this event.

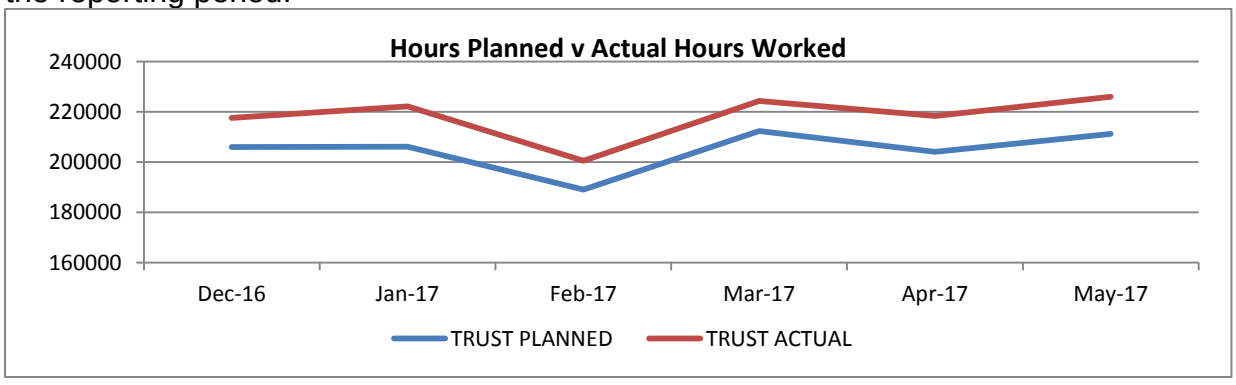
3.2.5 In general, to date to safe staffing has focussed more on inpatient nursing staff numbers, but within the forthcoming safe staffing programme we have identified the need to extend into community and multi-disciplinary working. The recent Learning Disability and Mental Health Service Specific guidance includes more detail on requirements of this approach which we will take into account. We have also used the content of this guidance to inform our current establishment review work, particularly by providing a framework for the professional judgement discussions.

3.2.6 The trust has a long established approach to continuous improvement and there are key associations with programmes such as the Purposeful Productive Community Service (PPCS) and Model Wards. A key component for the proposed safe staffing programme will be to ensure synergies with these existing programmes, so that they can feed into an overarching safe staffing approach. Update and progress against the pathway and workforce work stream within PPCS is being considered through EMT. The Safe Staffing programme will be co-ordinated within the overall Programme Office which has recently been established

3.3 Right place and right time

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

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



3.3.3 It is important to highlight that at no point during the 6 month review did the actual hours meet the planned. A key focus from the establishment review will be to address the need for flexible staffing across in-patient sites with the aim of reducing this gap.

3.3.4 Appendix 3 of the report shows the average fill rate (1st December to 31st May 2017) for both days and nights for both registered and non-registered staff. The 6 monthly position shows that there were 36 wards (over 50%) of wards who had fill rates of less than 89.9% (shown as red) for registered nurses on daytime shifts. In terms of unregistered nurses this equated to 7 wards on days that had a fill rate below 89.9%. This shows that although the trust usually meets its planned staffing numbers there is often a defecit of the planned skill mix. This presents risks in terms of the CQC focus and limits the quality of interventions that can be offered from a registered nursing perspective.

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

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

Month	Day				Night			
	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month
Dec-16	89.90	↓	114.20	↓	99.00	↓	116.00	↓
Jan-17	92.50	↑	116.20	↑	97.80	↓	119.10	↑
Feb-17	89.80	↓	115.40	↓	97.10	↓	116.80	↓
Mar-17	90.10	↑	114.80	↓	97.60	↑	115.70	↓
Apr-17	91.40	↑	114.90	↑	99.90	↑	117.50	↑
May-17	93.20	↑	115.10	↑	99.40	↓	115.40	↓

From the table it is important to highlight the following:

- The average fill rate for registered nurses on day shifts has improved from 89.90% in December 2016 when compared to 93.20% in May 2017 (3.3% increase).
- The average fill rate for health care assistants on day shifts has increased from 114.20% in December 2016 to 115.10% in May 2017 (0.9% increase).
- The average fill rate for registered nurses on night shifts has increased from 99.00% in December 2016 when compared to 99.40% in May 2017 (0.4% increase).
- The average fill rate for health care assistants on night shifts has deteriorated from 116.00% in December 2016 when compared to 115.40 in May 2017 (0.60% decrease).
- All fill rate indicators are within the 89.9% tolerance.

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

Locality	Total Number of Red Occurrences	Trend on previous 6 months
Durham & Darlington	2	↓ (5)
Teesside	12	↑ (4)
North Yorkshire	10	↑ (7)
Forensic Services	18	↓(22)
York and Selby	6	↓ (7)

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

3.3.8 The 6 month average highlights Primrose Lodge as having the lowest fill rate of 52.2% for registered nurses on days. The low fill rate is as a result of sickness and vacancies. The ward do flex the use of HCA to fill some of the vacant duties, this is evident by the HCA on days fill rate reporting at 128.6% over the 6 month period. In addition cover is provided by the Ward Manager and seeking support from the community team. Staffing levels are being reviewed on a daily basis as part of the huddle process. Posts are being recruited to and are awaiting for pre-employment checks.

3.3.9 The second lowest fill rate utilising the 6 month average highlights Springwood and The Orchards with a fill rate of 68.0%. Springwood is in relation to registered nurses on days as a result of vacancies and high patient acuity. The Orchards is in relation to unregistered nurses on days and relates to long term sickness and vacancies. A rolling recruitment campaign is in place with a number of recruitment events planned for the next couple of months. Assistance from other localities is being sought as well as from the neighbouring community teams although due to the short notice of such requests this presents with challenges. Processes are in place to regularly monitor staffing on a daily basis with a 'stop the line' approach in operation. A paper has recently been presented to Trust Board outlining this in detail along with an action plan.

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

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

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

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

Month	Number of duties	Number of Hours
Dec	1,499	15,120
Jan	1,512	17,396
Feb	1,317	14,466
Mar	1,428	14,951
Apr	1,450	15,624
May	1,521	16,699
TOTAL	**8,727**	**94,255**

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

- 8,727 additional duties were created within the reporting period this is an increase of 6 duties when compared to the previous 6 month period.

- The 8,727 additional duties created equates to 94,255 hours within the reporting period this is an increase of 5,505 hours when compared to the previous 6 month period and suggests that the length of a shift is increasing (average 10.8 hours per additional duty).

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

Ward / Team	Number of Duties	Number of Hours
Merlin Ward	700	7,630
Westwood Centre	601	6,293
Westerdale South	512	4,455
Clover/Ivy	494	5,276
Talbot Direct Care	363	4,082
Kestrel/Kite	350	3,945
Northdale Centre	327	2,622
Bedale Ward	281	3,167
Cedar Ward (D&D)	269	3,104
Fulmar Ward	261	2,853
	4,158	**43,427**

3.3.14 Further analysis of the usage of 'enhanced observations' in relation to budgeted establishments is required to fully understand the level of clinical need and practices at ward level and to seek an effective solution to bank usage. NHSI have recently announced a mental health observation and engagement collaborative and the safer staffing programme will seek to learn from this pilot and link in to Model Ward methodology.

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

Locality	Ward	Total Hours	Bank Usage%
Teesside	Westerdale South	9,695.80	**37.6%**
Durham & Darlington	Cedar	8,679.60	**33.6%**
Forensics	Merlin	9,808.40	**33.5%**
Forensics	Clover / Ivy	8,692.10	**31.8%**
Teesside	Bedale Ward	6,504.00	**29.9%**
Forensics	Northdale Centre	8,207.90	**28.6%**
Forensics	Mallard	6,422.00	**28.5%**
Durham & Darlington	Elm Ward	4,171.30	**25.3%**
Durham & Darlington	Birch Ward	4,892.00	**25.3%**

- This equates to 9 wards in 3 separate localities.

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

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

Locality	Ward	Total Hours	Agency Usage %
York & Selby	Acomb Garth	4,639.50	**34.7%**
York & Selby	Worsley Court	648.00	**26.6%**
North Yorkshire	Cedar (NY)	3768.45	**18.6%**
York & Selby	Ebor Ward	2563.00	**15.3%**
North Yorkshire	Springwood	2383.45	**11.9%**
North Yorkshire	Rowan Ward	1858.50	**10.2%**
York & Selby	Meadowfields	1630.50	**8.9%**
York & Selby	Minster Ward	945.50	**6.0%**
York & Selby	Oak Rise	737.00	**3.4%**
Forensics	Northdale Centre	686.25	**2.4%**
Forensics	Harrier / Hawk	495.00	**2.1%**
York & Selby	Cherry Tree House	306.50	**1.6%**
Forensics	Kestrel / Kite.	76.00	**0.3%**

- This equates to 13 wards in 3 separate localities.

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

Locality	Ward Name	Total Hours	Overtime Usage %
Teesside	Bankfields Court Unit 4	212.17	10.3%
Teesside	Bankfields Court Unit 2	1,395.21	10.2%
Durham & Darlington	Holly	709.21	8.7%
Teesside	Baysdale	1,266.85	8.5%
Teesside	Westwood Centre	2,694.21	8.3%
Teesside	Bankfields Court Unit 3	158.17	6.8%
North Yorkshire	Cedar (NY)	1,367.4	6.7%
York & Selby	Minster Ward	1,047.24	6.6%
Forensics	Mandarin	1,198.5	6.4%

Locality	Ward Name	Total Hours	Overtime Usage %
Durham & Darlington	Maple	889.82	5.6%
North Yorkshire	Ayckbourn Danby Ward	765.42	5.5%
North Yorkshire	Ward 14	822.5	5.5%
Teesside	Bankfields Court Flats	104.84	5.5%
North Yorkshire	Springwood	1,052.87	5.3%
North Yorkshire	Rowan Lea	1,133.47	5.1%
Teesside	The Lodge	88.17	5.1%
York & Selby	Ebor Ward	858.05	5.1%
Durham & Darlington	Bek-Ramsey Wards	1,246.66	4.8%
Teesside	Westerdale North	789.42	4.7%
Teesside	Bilsdale	726.75	4.6%
Durham & Darlington	Hamsterley	876.93	4.5%
York & Selby	Cherry Tree House	854.5	4.4%
Teesside	Newberry Centre	991.91	4.3%
Forensics	Clover / Ivy	1,159.17	4.2%
Teesside	Bedale Ward	913.5	4.2%
Teesside	Bankfields Court	1,668.12	4.2%
Durham & Darlington	Primrose Lodge	604.48	4.1%
Durham & Darlington	Willow Ward	690.33	4.1%
Forensics	Northdale Centre	1,166.66	4.1%
Teesside	Stockdale	651.75	4.1%

- All wards across the trust are using overtime.
- Teesside are using the most overtime (14,648.43) whilst York & Selby are using the least (3,779.33).
- There are 13 wards who have utilised bank, agency and overtime within the reporting period as outlined below:

Ward Name	Locality	Speciality	Bank Usage Vs Actual Hours	Agency Usage Vs Actual Hours	Overtime Usage Vs Actual Hours
Harrier / Hawk	Forensics	Forensic LD	16.7%	2.1%	3.7%
Kestrel / Kite	Forensics	Forensic LD	21.2%	0.3%	3.1%
Northdale Centre	Forensics	Forensic LD	28.6%	2.4%	4.1%
Cedar (NY)	North Yorkshire	AMH	7.5%	18.6%	6.7%
Rowan Ward	North Yorkshire	MHSOP	12.4%	10.2%	3.8%
Springwood	North Yorkshire	MHSOP	10.1%	11.9%	5.3%
Acomb Garth	York & Selby	MHSOP	2.4%	34.7%	2.7%
Ebor Ward	York & Selby	AMH	4.7%	15.3%	5.1%
Minster Ward	York & Selby	AMH	15.2%	6.0%	6.6%
Oak Rise	York & Selby	LD	6.5%	3.4%	2.5%
Meadowfields	York & Selby	MHSOP	20.6%	8.9%	0.6%
Worsley Court	York & Selby	MHSOP	3.8%	26.6%	0.5%
Cherry Tree House	York & Selby	MHSOP	3.6%	1.6%	4.4%

3.4 Patient outcomes, people productivity and financial sustainability

3.4.1 The NQB guidance states that boards will need to collaborate across their local health and care system, with commissioners and other providers, to ensure delivery of the best possible care and value for patients and the public. This may require NHS provider boards to make difficult decisions about resourcing as local Sustainability and Transformation

Plans are developed and agreed. It is critical that boards review workforce metrics, indicators of quality and outcomes, and measures of productivity on a monthly basis – as a whole and not in isolation from each other – and that there is evidence of continuous improvements across all of these areas.

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

No. of SUI's	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	RN Nights	HCA Days	HCA Nights
2	Hamsterley	13.9%	**94.7%**	**104.1%**	**117.5%**	**125.5%**
2	Cedar (NY)	7.5%	**83.0%**	**87.8%**	**108.5%**	**121.9%**
1	Ceddesfeld	6.3%	**95.9%**	**100.0%**	**115.9%**	**102.5%**
1	Rowan Lea	3.5%	**101.0%**	**109.0%**	**112.8%**	**104.8%**
1	Springwood	10.1%	**68.0%**	**101.7%**	**132.4%**	**159.9%**
1	Ward 14	2.3%	**71.5%**	**101.3%**	**124.3%**	**102.4%**
1	Overdale	13.8%	**84.9%**	**100.7%**	**112.7%**	**108.6%**
1	Lustrum Vale	13.3%	**83.6%**	**100.9%**	**123.3%**	**107.3%**
1	Westerdale South	37.6%	**104.1%**	**99.6%**	**127.0%**	**125.2%**
1	Wingfield	10.0%	**95.6%**	**102.9%**	**113.1%**	**103.2%**

- From those wards that did have an SUI within the reporting period all had a 'green' or 'amber' rating for their bank usage.
- There were 6 fill rate indicators that were reported as 'red'; all but one of the fill rate indicators related to registered nurses on days.
- All other fill rate indicators are reporting as either 'green' or 'blue'.

The Patient Safety investigation team have been asked to specifically consider staffing levels and skill mix in relation to their investigation of inpatient SI's to support more robust triangulation of staffing data and aid root cause analysis. During the reporting period there were no actions attributable to low staffing levels or skill mix. However, there was an action in relation to agency staff not being able to access the electronic care record and another in relation to the provision of physiotherapy staff.

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

No. L4 Incidents	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	RN Nights	HCA Days	HCA Nights
2	Hamsterley	13.9%	**94.7%**	**104.1%**	**117.5%**	**125.5%**
4	Cedar (NY)	7.5%	**83.0%**	**87.8%**	**108.5%**	**121.9%**
1	Ceddesfeld	6.3%	**95.9%**	**100.0%**	**115.9%**	**102.5%**
1	Rowan Lea	3.5%	**101.0%**	**109.0%**	**112.8%**	**104.8%**
1	Springwood	10.1%	**68.0%**	**101.7%**	**132.4%**	**159.9%**
1	Ward 14	2.3%	**71.5%**	**101.3%**	**124.3%**	**102.4%**
1	Overdale	13.8%	**84.9%**	**100.7%**	**112.7%**	**108.6%**
1	Lustrum Vale	13.3%	**83.6%**	**100.9%**	**123.3%**	**107.3%**
1	Westerdale South	37.6%	**104.1%**	**99.6%**	**127.0%**	**125.2%**
1	Wingfield	10.0%	**95.6%**	**102.9%**	**113.1%**	**103.2%**

- From those wards that did have an SUI within the reporting period all had a 'green' or 'amber' rating for their bank usage.
- There were 6 fill rate indicators that were reported as 'red'; all but one of the fill rate indicators related to registered nurses on days.
- All other fill rate indicators are reporting as either 'green' or 'blue'.

3.4.4 There were 30 level 3 self-harm incidents occurred within the reporting period. These are summarised below utilising the bank and staffing fill rates as comparative data:

No. L3 (self-harm) Incidents	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	RN Nights	HCA Days	HCA Nights
1	Elm Ward	25.3%	**97.6%**	**101.2%**	**109.1%**	**115.6%**
1	Maple	12.6%	**88.6%**	**98.9%**	**99.8%**	**107.0%**
2	Oak Ward	2.9%	**98.6%**	**100.4%**	**94.2%**	**101.9%**
2	Clover / Ivy	31.8%	**94.8%**	**102.7%**	**122.2%**	**174.8%**
3	Brambling	9.1%	**88.1%**	**100.7%**	**102.2%**	**99.2%**
1	Sandpiper Ward	22.5%	**89.6%**	**80.3%**	**117.5%**	**165.4%**
1	Swift Ward	21.9%	**81.9%**	**100.1%**	**114.3%**	**131.7%**
3	Fulmar Ward	19.4%	**91.2%**	**98.3%**	**113.5%**	**140.9%**
3	Ayckbourn Esk Ward	12.8%	**77.5%**	**106.5%**	**118.3%**	**96.5%**
1	Cedar (NY)	7.5%	**83.0%**	**87.8%**	**108.5%**	**121.9%**
1	Bransdale	29.9%	**85.1%**	**99.5%**	**141.8%**	**133.9%**
1	Lincoln Ward	6.3%	**101.7%**	**98.8%**	**100.9%**	**108.7%**
2	Overdale	13.8%	**84.9%**	**100.7%**	**112.7%**	**108.6%**
1	Newberry Centre	12.5%	**85.7%**	**103.2%**	**122.4%**	**125.0%**
1	The Evergreen Centre	5.3%	**94.0%**	**105.5%**	**129.6%**	**108.3%**
4	Westwood Centre	17.2%	**103.6%**	**103.3%**	**143.2%**	**188.3%**
1	Ebor Ward	4.7%	**94.2%**	**97.1%**	**95.5%**	**111.0%**
1	Cherry Tree House	3.6%	**98.7%**	**94.6%**	**88.3%**	**114.1%**

- From the 30 level 3 self-harm incidents this equated to 18 wards across 5 localities.
- Teesside and Forensic Services had the highest number of level 3 incidents in the reporting period with 10 incidents in total.
- Westwood Centre had the highest number of level 3 incidents across the reporting period with 4 incidents.
- 11 out of 18 wards reported as 'amber' for their bank usage whilst all the others reported as 'green'.
- There were 12 fill rate indicators that reported as 'red' whilst the others all reported as either 'green' or 'blue'.

3.4.5 There were 33 complaints raised during the reporting period. These are summarised below utilising the bank and staffing fill rates as comparative data:

No. of Complaints	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	RN Nights	HCA Days	HCA Nights
1	Cedar	33.6%	**102.2%**	**100.6%**	**189.1%**	**160.0%**
3	Elm Ward	25.3%	**97.6%**	**101.2%**	**109.1%**	**115.6%**
2	Farnham Ward	5.4%	**129.5%**	**102.4%**	**103.1%**	**101.7%**

No. of Complaints	Ward	Bank Fill Rate	Staffing Fill Rates			
			RN Days	RN Nights	HCA Days	HCA Nights
1	Birch Ward	25.3%	**97.1%**	**97.2%**	**106.4%**	**111.5%**
2	Harrier / Hawk	16.7%	**85.4%**	**98.1%**	**113.5%**	**122.9%**
2	Northdale Centre	28.6%	**81.1%**	**88.5%**	**122.5%**	**97.7%**
1	Lark	11.1%	**90.4%**	**103.3%**	**104.4%**	**98.7%**
1	Mandarin	17.3%	**83.9%**	**106.4%**	**121.9%**	**125.3%**
1	Sandpiper Ward	22.5%	**89.6%**	**80.3%**	**117.5%**	**165.4%**
1	Ayckbourn Danby Ward	14.6%	**74.5%**	**94.5%**	**106.5%**	**97.0%**
3	Ayckbourn Esk Ward	12.8%	**77.5%**	**106.5%**	**118.3%**	**96.5%**
3	Rowan Lea	3.5%	**101.0%**	**109.0%**	**112.8%**	**104.8%**
2	Rowan Ward	12.4%	**89.4%**	**99.6%**	**140.6%**	**133.1%**
2	Bedale Ward	29.9%	**82.0%**	**110.7%**	**190.7%**	**117.5%**
1	Bransdale	29.9%	**85.1%**	**99.5%**	**141.8%**	**133.9%**
2	Lincoln Ward	6.3%	**101.7%**	**98.8%**	**100.9%**	**108.7%**
1	Overdale	13.8%	**84.9%**	**100.7%**	**112.7%**	**108.6%**
1	Stockdale	15.1%	**97.5%**	**99.3%**	**107.1%**	**104.4%**
1	Newberry Centre	12.5%	**85.7%**	**103.2%**	**122.4%**	**125.0%**
1	Cherry Tree House	3.6%	**98.7%**	**94.6%**	**88.3%**	**114.1%**

- None of the complaints raised cited issues with staffing levels or skill mix.
- North Yorkshire locality had the highest number of complaints in the reporting period with 9 complaints raised.
- 5 of those wards listed reported as ‘green’ for bank usage whilst the remaining 14 wards reported as ‘amber’.
- 14 fill rate indicators were reporting as ‘red’ with 11 of these relating to registered nurses on days. All other metrics are reporting as either ‘green’ or ‘blue’.

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

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

Ward	Locality	Incidents of Restraint				Bank Usage
		Incidents	PRO used	Other	Restraint Total	
Sandpiper	Forensics	544	37	1378	1415	22.5%
The Evergreen Centre	Teesside	404	0	597	597	5.3%
Newberry Centre	Teesside	284	4	469	473	12.5%
Westwood Centre	Teesside	246	5	433	438	17.2%
Springwood	North Yorkshire	191	0	227	227	10.1%
Merlin	Forensics	147	7	198	205	33.5%
Fulmar	Forensics	110	0	173	173	19.4%
Cedar	Durham & Darlington	105	6	171	177	33.6%
Kestrel/Kite	Forensics	79	2	165	167	21.2%
Clover/Ivy	Forensics	75	0	147	147	31.8%

- Sandpiper had 544 incidents requiring the use of restraint during the reporting period. This equated to 1415 restraints of which 37 were recorded as 'Prone'.
- 8 of the wards identified within the top 10 had an 'amber' rating for their bank usage whilst the others reported as 'green'.

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

Ward Name	Registered Average %		Unregistered Average %	
	Day	Night	Day	Night
Sandpiper Ward	89.6%	80.3%	117.5%	165.4%
The Evergreen Centre	94.0%	105.5%	129.6%	108.3%
Newberry Centre	85.7%	103.2%	122.4%	125.0%
Westwood Centre	103.6%	103.3%	143.2%	188.3%
Springwood	68.0%	101.7%	132.4%	159.9%
Merlin	104.3%	92.4%	155.9%	209.8%
Fulmar Ward	91.2%	98.3%	113.5%	140.9%
Cedar	102.2%	100.6%	189.1%	160.0%
Kestrel / Kite.	95.4%	96.4%	122.5%	147.9%
Clover / Ivy	94.8%	102.7%	122.2%	174.8%

3.4.9 With reThe use of Prone restraint will continue to be monitored within the Positive and Safe team and monthly within the Safe Staffing reports, however, it is worth highlighting that during the reporting period there were 80 episodes of Prone used. This is a reduction of 10 incidents when compared to the previous 6 month report.

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

The 9 indicators include:

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

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

3.4.12 Falls that have resulted in significant harm for all inpatient services have been examined. Within the reporting period there have been a total of 8 incidents across 7 wards. The ward and teams that these each relate to are as follows:

Speciality	Ward / Team	Number of incidents
MHSOP	Ceddesfeld	1
MHSOP	Hamsterley	2
MHSOP	Rowan Lea	1
MHSOP	Springwood	1
MHSOP	Ward 14	1
MHSOP	Westerdale South	1
MHSOP	Wingfield	1

- All of the falls incidents have occurred within the older people's service due to other health problems that they may encounter such as reduced vision, mobility and balance problems.

- In turning to the triangulation of data with the safe nursing indicators the following is of relevance:
  - The only wards to have a 'red' rated fill rate were in relation to Springwood and Ward 14 in relation to registered nurses on days. All other fill rates are reporting as either 'green' or 'blue'.
  - Hamsterley, Springwood, Westerdale South and Wingfield all had an 'amber' rated bank usage. All other bank usage rates are reporting as 'green'.
  - Agency and overtime are reporting as 'green' for all 7 wards

3.4.13 Data in relation to pressure ulcers was obtained covering the reporting period. There were 4 incidents reported across 3 wards as follows:

Speciality	Ward / Team	Number of incidents
AMH	Cedar	1
Forensics	Mallard	1
MHSOP	Meadowfields	2

- 2 of the 4 incidents occurred within older people's service which would be expected.
- In turning to the triangulation of staffing data:
  - Mallard and Meadowfields had at least one metric within the staffing fill rate that was classified as 'red'. All other fill rate indicators are reporting as either 'green' or 'blue'
  - All 3 wards are reporting as 'amber' for bank usage.
  - Agency workers were utilised within Meadowfields.
  - Overtime was worked across all of the wards listed.

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

3.4.15 There were 423 incidents of medication errors reported within the reporting period across 73 wards. The top 6 wards are shown as follows:

Ward / Team	Number of incidents
Meadowfields	23
Westerdale North	21
Swift	16
Brambling	14
Cherry Tree	14
Westwood Centre	13
Bransdale	13

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

3.4.16 In terms of shifts worked without a break there were 2,666 shifts worked within the reporting period where breaks were not given. The top 5 wards were as follows:

WARD	No of eligible shifts	No. of eligible shifts without breaks 1st Jun 16 – 30th Nov 16	% of shifts without break	Days without breaks	Nights without break
Bankfields Court	1785	430	24%	403	27
Meadowfields	1702	241	14%	23	218
Newberry Centre	3206	237	7%	189	48
Cedar (NY)	1752	104	6%	73	31
Minster Ward	1688	98	6%	65	33

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

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

Ward Name	Registered Average %		Unregistered Average %	
	Day	Night	Day	Night
Bankfields Court	**81.6%**	**99.3%**	**103.2%**	**96.8%**
Meadowfields	**82.2%**	**91.9%**	**83.7%**	**104.0%**
Newberry Centre	**85.7%**	**103.2%**	**122.4%**	**125.0%**
Cedar (NY)	**83.0%**	**87.8%**	**108.5%**	**121.9%**
Minster Ward	**112.2%**	**104.8%**	**95.0%**	**99.8%**

- There are 6 fill rate indicator's that are reporting as 'red' of which 4 are in relation to registered nurses on days and a further indicator related to nights.

- There is 1 fill rate indicator that is reporting as 'red' which relates to Meadowfields and unregistered nurses on days.
- All other indicators are reporting as either 'green' or 'blue'.

3.4.17 Breaks not taken due to clinical need is being monitored through the clinical report outs.

3.5 Reporting, investigating and acting on incidents

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

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

3.5.3 It is also important to look at the number of incidents that have been raised and categorised in relation to staffing levels. Within the reporting period there were 74 incidents raised citing issues with staffing. This is a reduction of 47 when compared to the previous 6 month report. The incidents citing staffing problems were from the following localities:

Locality	Number of incidents raised	Trend on previous 6 month
North Yorkshire	11	↓ (39)
Durham & Darlington	16	↓ (19)
Teesside	12	↓ (21)
Forensics	27	↑ (20)
York and Selby	8	↓ (22)

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

- An incident was reported highlighting that on the 30th May 2017 Willow Ward (night duty) were left without a registered nurse due to sickness reported earlier that afternoon. The use of the escalation process has been reinforced.
- The majority were raised highlighting that there were inadequate staffing within the ward for a particular shift

- Due to staffing, wards would be unable to provide a response should this be required during the course of the shift.
- Occasions whereby there would be insufficient staffing to undertake physical restraint or a response should this be required during the course of the shift.
- Other reasons were highlighted and include:
    - Staff not being able to take breaks
    - Unable to carry out regular reviews for those patients on seclusion, supervise patients or carry out escorts.
    - Short notice sickness has presented issues with obtaining appropriate cover
    - Occasions whereby bank workers have cancelled the shift on the electronic system
    - Staffing compliment made up entirely of agency workers or at best with a unregistered nurse
    - Unable to carry out correct level of observations
    - Delays in undertaking the medication round
    - Concerns relating to ability to provide quality of care

The trust adopted an escalation process to ensure a standard approach was adopted across the Trust and a timely response to ensure patient safety is not compromised. The escalation process will be reviewed as part of the safe staffing programme to ensure that it is delivering what it was intended to do since its introduction. Monthly monitoring of this occurs within the monthly safe staffing reports.

3.6 Patient, staff and carer feedback

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

3.6.2 A further analysis of the 32 complaints has been undertaken to identify whether there were any specific issues rose citing staffing levels. The review concluded that there was 1 complaint raised citing concerns around a number of things with staffing shortages being one of these. The complaints were in relation to Birch Ward and were raised in April 2017.

3.6.3 In addition analysis has been undertaken with regards to patient and carer feedback that has been submitted in relation to the friends and family test. In April 2017 the Trust introduced a new system (Meridian) to capture the friends and family test and a new question was introduced; is there anything we could do to make the service better? 18 comments were received that suggested more staff was required within our inpatient wards to support further activities and enhance communication.

3.6.4 The trust receives compliments and these are captured and published via the weekly e-Bulletin. A total of 443 compliments were received during the reporting period covering all localities. A further review has been undertaken and these highlight a number of individuals

and commend the work they have undertaken but nothing specific in relation to actual staffing levels.

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

3.7 Care hours per patient day (CHPPD)

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

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

3.8.1 Previous reports have highlighted the Learning Disability specific safe staffing guidance which built on the general NQB guidance of 2016. This guidance included the outlining of an approach to conducting staffing reviews, and the need for flexible contingency planning and an adaptable workforce in view of future service models. A regional task and finish group has since been established by Health Education England to review the current picture around Learning Disability nurse training, recognising some of the issues around recruitment and pre-registration training highlighted earlier in our own report (section 3.2.4)

3.8.2 Further guidance has since emerged in draft format for mental health services; 'Safe sustainable and productive staffing, an improvement resource from mental health services' (2017). As with previous guidance this is structured around the three NQB themes of right staff, right shills, right place and time, and highlights the need to undertake evidence – based workforce planning including strategic establishment reviews. The review requires a combination of professional judgment and evidence based tools, with the Hurst tool remaining the recommended format. It makes the following recommendations which Boards should seek assurance on:

- **Right Staff:**
  - The organisation has systems to monitor staffing requirements across all services (based on acuity and demand) and these are measured and reviewed against actual team staffing levels.
  - There is an agreed process for escalating to the board significant issues that affect safe and sustainable staffing
  - Staffing reports take account of local factors that affect safe delivery of services.
  - The annually agreed 'headroom' percentage uplift reflects organisational needs, is deliverable and achieved.
  - Clinical leaders and managers have allocated sufficient time to supervise and lead effectively.

- There is an annual review of the safe, sustainable, staffing references benchmarking data that the organisation has access to (both internal and external).

- **Right Skills:**
  - The organisation has processes to identify, analyse and implement evidence-based practice across services.
  - Where new care models are developed, a clear plan exists to support staff so that the change takes place safely and affordably.
  - There are clear plans to evaluate the changes and both are reviewed.
  - The organisation takes an evidence-based approach to support efficient and effective team working.
  - The organisation has systems and processes to promote staff's physical and emotional wellbeing and prevent fatigue and burnout.
  - The organisation has a strategy for retaining staff, which clearly states learning and development opportunities for all staff groups and plans for attracting, recruiting and retaining staff, aligned with the workforce plan.

- **Right Place and Time:**
  - Standard approaches across services prevent unwarranted clinical variation in service provision.
  - Technology is available to staff to undertake their duties safely, efficiently and effectively.
  - Embedded quality improvement methods enable clinical teams to identify waste and make changes at service level to improve quality.
  - Regular reviews of shift patterns and e-Rostering support the efficient delivery of care and treatment.
  - Thresholds for using bank and agency staffing are set, monitored and responded to, with temporary staff recruited wherever possible from in-house staffing banks.
  - Service models and staffing deployment reflect demand, including seasonal or other variation (across seven-day services where appropriate).

3.8.3 The document sets out a recommended approach to establishment reviews, which has been taken into account with the existing safe staffing work streams and will be taken further forward with the forthcoming Programme. There is also an expectation that the work expands into community services, as with previous guidance.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

No direct risks to patient safety from the staffing data have been identified in this 6 monthly report. There is a risk to CQC compliance if we fail to achieve our planned registered nursing levels on a daily basis. This will need to be closely monitored through the monthly and 6 monthly staffing reports to Board, mitigation is being addressed through the initiatives set out in this report that will be delivered through the safe staffing programme.

4.2 Financial/Value for Money:

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

4.3 Legal and Constitutional (including the NHS Constitution):

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

The Trust has complied with these directives to date.

4.4 Equality and Diversity:

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

4.5 Other implications:

There are no other implications identified

5.0 RISKS:

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

6.0 CONCLUSIONS:

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

6.2 The safe staffing work stream will continue to review existing processes and prepare for the new requirements and any guidance during the financial year 2017/18 whilst the programme is fully established. Data collection and analysis will be further developed and reported upon in future reports.

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

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

7.0 RECOMMENDATIONS:

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

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

July 2017

APPENDIX 1

Establishment Review Guidance

Clinical Team
Establishment Review

Budgeted and Actual Staffing Establishments in WTE

Appendix 2

Locality	WARD	Speciality	Establishment at 1/12/16				Establishment at 31/5/17				Comparison 01/12/16 to31/05/17 Budget v actual WTE hours			
			Registered Staff		Unregistered Staff		Registered staff		Unregistered staff		Registered Staff		Unregistered Staff	
			Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
Durham & Darlington	Cedar Ward	Adults	9.50	9.80	14.30	15.20	8.50	9.80	14.30	15.00	-1.00	0.00	0.00	-0.20
	Birch Ward	Adults	8.60	5.60	15.90	10.70	9.60	10.40	15.90	13.70	1.00	4.80	0.00	3.00
	Primrose Lodge	Adults	8.60	8.00	11.40	13.00	8.60	6.00	11.40	10.00	0.00	-2.00	0.00	-3.00
	Willow Ward	Adults	8.60	9.30	12.40	13.90	8.60	9.40	12.40	12.10	0.00	0.10	0.00	-1.80
	Maple Ward	Adults	8.60	9.40	11.40	10.60	8.60	9.30	11.40	11.60	0.00	-0.10	0.00	1.00
	Elm Ward	Adults	8.60	8.50	11.40	11.00	8.60	7.80	11.40	10.40	0.00	-0.70	0.00	-0.60
	Farnham Ward	Adults	8.60	10.60	11.40	10.60	8.60	10.60	11.40	10.60	0.00	0.00	0.00	0.00
	Tunstall Ward	Adults	8.60	9.00	11.40	11.60	8.60	12.00	11.40	11.60	0.00	3.00	0.00	0.00
	Holly Unit	CYPS	4.60	4.60	5.60	5.60	4.60	3.80	5.60	4.80	0.00	-0.80	0.00	-0.80
	Bek, Talbot Wards	LD	9.60	7.40	25.70	25.00	9.60	8.60	25.70	25.00	0.00	1.20	0.00	0.00
	Ceddesfeld Ward	MHSOP	8.60	9.40	13.20	15.30	8.60	8.40	13.20	15.30	0.00	-1.00	0.00	0.00
	Hamsterley Ward	MHSOP	8.60	9.40	13.20	13.00	8.60	9.40	13.20	13.00	0.00	0.00	0.00	0.00
	Oak Ward	MHSOP	8.60	8.80	11.40	11.20	8.60	8.80	11.40	12.30	0.00	0.00	0.00	1.10
	Roseberry Wards	MHSOP	8.60	8.30	12.40	12.00	8.60	6.70	12.40	12.00	0.00	-1.60	0.00	0.00
Forensics	Clover/Ivy	Forensics LD	8.10	8.00	20.20	20.10	8.10	6.00	20.20	17.80	0.00	-2.00	0.00	-2.30
	Thistle Ward	Forensics LD	10.70	6.00	14.80	13.90	10.70	5.00	14.80	14.40	0.00	-1.00	0.00	0.50
	Northdale Centre	Forensics LD	8.10	8.00	27.80	23.90	8.10	8.00	26.80	21.70	0.00	0.00	-1.00	-2.20
	Oakwood	Forensics LD	8.10	8.70	6.60	8.00	8.10	8.10	6.60	8.80	0.00	-0.60	0.00	0.80
	Eagle/Osprey	Forensics LD	8.10	12.70	17.50	18.80	8.10	9.80	17.50	17.10	0.00	-2.90	0.00	-1.70
	Harrier/Hawk	Forensics LD	8.10	8.90	20.20	17.80	8.10	5.80	20.20	16.90	0.00	-3.10	0.00	-0.90
	Langley Ward	Forensics LD	8.10	6.00	9.30	10.00	8.10	7.00	8.30	7.00	0.00	1.00	-1.00	-3.00
	Kestrel/Kite	Forensics LD	8.10	9.80	22.00	26.60	8.10	9.80	22.00	22.60	0.00	0.00	0.00	-4.00

	Brambling Ward	Forensics MH	8.10	8.00	13.20	15.20	8.10	7.00	13.20	14.70	0.00	-1.00	0.00	-0.50
	Jay Ward	Forensics MH	8.10	7.30	13.40	13.00	8.10	7.50	13.20	12.80	0.00	0.20	-0.20	-0.20
	Sandpiper Ward	Forensics MH	10.70	10.00	17.10	17.50	10.70	8.50	17.90	14.10	0.00	-1.50	0.80	-3.40
	Merlin	Forensics MH	10.70	9.50	15.30	14.20	10.70	9.50	15.30	14.20	0.00	0.00	0.00	0.00
	Swift Ward	Forensics MH	8.10	8.90	15.30	16.70	8.10	7.90	15.30	14.10	0.00	-1.00	0.00	-2.60
	Fulmar Ward.	Forensics MH	8.10	8.20	15.30	14.20	8.10	8.10	15.30	14.20	0.00	-0.10	0.00	0.00
	Lark	Forensics MH	8.10	7.40	13.20	14.00	8.10	7.40	13.20	14.00	0.00	0.00	0.00	0.00
	Kirkdale Ward	Forensics MH	8.10	7.80	15.30	14.90	8.10	7.90	15.30	14.80	0.00	0.10	0.00	-0.10
	Mallard Ward	Forensics MH	8.10	6.60	15.30	16.50	8.10	5.60	15.30	15.50	0.00	-1.00	0.00	-1.00
	Mandarin	Forensics MH	8.10	9.00	13.20	13.40	8.10	7.90	13.20	12.50	0.00	-1.10	0.00	-0.90
	Nightingale Ward	Forensics MH	8.10	7.00	13.20	13.70	8.10	7.90	13.20	13.20	0.00	0.90	0.00	-0.50
	Linnet Ward	Forensics MH	8.10	5.90	11.20	14.00	8.10	7.90	13.20	13.00	0.00	2.00	2.00	-1.00
	Newtondale Ward	Forensics MH	10.70	8.00	17.90	18.60	10.70	10.00	17.90	17.40	0.00	2.00	0.00	-1.20
North Yorkshire	Abdale House (The Orchards)	Adults	10.70	10.80	5.40	5.60	10.70	11.10	5.40	6.10	0.00	0.30	0.00	0.50
	Ayckbourn Unit Danby Ward	Adults	8.10	4.00	10.70	12.00	8.10	5.00	10.70	9.80	0.00	1.00	0.00	-2.20
	Ayckbourn Unit Esk Ward	Adults	10.10	7.40	10.70	11.60	10.10	7.40	10.70	11.60	0.00	0.00	0.00	0.00
	Ward 15 Friarage	Adults	9.10	8.00	10.70	11.50	9.10	6.00	10.70	9.50	0.00	-2.00	0.00	-2.00
	Cedar Ward (NY)	Adults	9.10	7.30	15.20	12.00	9.10	7.70	15.20	10.00	0.00	0.40	0.00	-2.00
	Ward 14	MHSOP	8.10	7.80	10.00	10.40	8.10	7.80	10.00	9.40	0.00	0.00	0.00	-1.00
	Rowan Ward	MHSOP	8.10	8.60	10.70	11.30	8.90	9.30	12.70	11.30	0.80	0.70	2.00	0.00
	Springwood Community Unit	MHSOP	8.10	7.00	12.50	12.00	8.10	6.00	12.50	10.40	0.00	-1.00	0.00	-1.60
	Rowan Lea	MHSOP	8.10	8.40	17.90	19.40	8.10	8.40	17.90	19.40	0.00	0.00	0.00	0.00
Teesside	Bedale Ward	Adults	8.20	7.00	13.70	13.70	8.20	7.00	13.70	11.80	0.00	0.00	0.00	-1.90
	Bilsdale Ward	Adults	8.20	7.80	11.00	10.70	8.20	8.00	11.00	12.00	0.00	0.20	0.00	1.30
	Bransdale Ward	Adults	8.20	8.80	10.00	8.00	8.20	7.80	10.00	9.00	0.00	-1.00	0.00	1.00

	Overdale Ward	Adults	8.20	8.60	11.00	9.80	8.20	8.60	11.00	9.40	0.00	0.00	0.00	-0.40
	Stockdale Ward	Adults	8.20	7.60	11.00	8.60	8.20	8.80	11.00	10.90	0.00	1.20	0.00	2.30
	Lincoln Ward	Adults	9.70	9.40	11.90	13.90	9.70	6.90	12.90	13.90	0.00	-2.50	1.00	0.00
	Lustrum Vale	Adults	10.30	11.00	11.00	10.30	10.30	8.50	11.00	10.30	0.00	-2.50	0.00	0.00
	Baysdale	CYPS	6.70	7.10	12.70	12.50	6.70	7.60	12.70	13.30	0.00	0.50	0.00	0.80
	Newberry Centre	CYPS	12.70	14.50	15.20	16.60	12.70	14.00	15.20	17.00	0.00	-0.50	0.00	0.40
	The Evergreen Centre	CYPS	13.50	17.10	18.30	19.90	13.50	15.00	18.70	23.70	0.00	-2.10	0.40	3.80
	Westwood Centre	CYPS	14.70	15.40	16.50	16.90	14.70	14.00	16.50	18.90	0.00	-1.40	0.00	2.00
	Thornaby Road	LD	3.40	3.60	10.30	9.70	3.60	3.40	11.90	9.20	0.20	-0.20	1.60	-0.50
	Aysgarth	LD	6.00	5.40	11.50	9.50	6.00	6.00	11.50	9.20	0.00	0.60	0.00	-0.30
	Bankfields Court Unit 2	LD	6.60	7.80	9.50	7.80	6.60	7.00	9.50	7.60	0.00	-0.80	0.00	-0.20
	Bankfields Court	LD	14.30	18.10	58.30	45.20	15.30	10.80	58.30	35.90	1.00	-7.30	0.00	-9.30
	Wingfield Ward	MHSOP	8.80	7.80	9.10	9.70	8.80	8.80	9.10	8.80	0.00	1.00	0.00	-0.90
	Westerdale South	MHSOP	8.20	10.40	11.00	12.60	8.20	10.20	11.00	13.90	0.00	-0.20	0.00	1.30
	Westerdale North	MHSOP	8.20	9.20	11.00	11.40	8.20	8.40	11.00	11.40	0.00	-0.80	0.00	0.00
York & Selby	Ebor Ward	Adults	9.40	6.50	11.70	8.50	9.40	8.50	11.70	10.70	0.00	2.00	0.00	2.20
	Minster Ward	Adults	9.40	8.80	11.70	5.40	9.40	9.90	11.70	6.80	0.00	1.10	0.00	1.40
	Cherry Tree House	MHSOP	11.20	10.80	15.00	12.20	11.70	9.40	14.50	14.20	0.50	-1.40	-0.50	2.00
	Oak Rise	ALD	9.40	11.50	21.20	20.20	9.40	12.40	21.20	17.00	0.00	0.90	0.00	-3.20
	Worsley Court	MHSOP	9.00	6.60	13.50	17.10	0.00	0.00	0.00	0.00	-9.00	-6.60	-13.50	-17.10
	Acomb Garth	MHSOP	0.00	0.00	0.00	0.00	11.00	8.70	13.50	17.40	11.00	8.70	13.50	17.40
	Meadowfields	MHSOP	9.30	6.20	13.50	14.80	9.30	8.20	13.50	11.80	0.00	2.00	0.00	-3.00

Average fill rate covering the period of 1st December 2016 to 31st May 2017

Appendix 3

Ward Name	Locality	Speciality	Bed Numbers (MAY)	6 Months - 1st December 2016 to 31st May 2017					
				Registered Average %		Unregistered Average %		Bank Usage vs Actual Hours	
				Day	Night	Day	Night	Hours	% against Actual Hours
Cedar	Durham & Darlington	AMH	10	102.2%	100.6%	189.1%	160.0%	8679.58	33.6%
Elm Ward	Durham & Darlington	AMH	20	97.6%	101.2%	109.1%	115.6%	4171.25	25.3%
Farnham Ward	Durham & Darlington	AMH	20	129.5%	102.4%	103.1%	101.7%	930.00	5.4%
Maple	Durham & Darlington	AMH	20	88.6%	98.9%	99.8%	107.0%	1995.09	12.6%
Primrose Lodge	Durham & Darlington	AMH	15	52.2%	100.6%	128.6%	100.0%	1303.50	8.7%
Tunstall Ward	Durham & Darlington	AMH	20	112.9%	117.0%	111.5%	101.4%	288.00	1.6%
Willow Ward	Durham & Darlington	AMH	15	94.3%	99.0%	153.1%	102.0%	1554.83	9.2%
Holly	Durham & Darlington	CYPS	4	149.8%	117.1%	126.1%	133.9%	865.16	10.6%
Birch Ward	Durham & Darlington	ED	15	97.1%	97.2%	106.4%	111.5%	4891.99	25.3%
Bek-Ramsey Wards	Durham & Darlington	LD	11	109.0%	100.5%	124.2%	103.2%	994.67	3.8%
Ceddesfeld	Durham & Darlington	MHSOP	15	95.9%	100.0%	115.9%	102.5%	1206.18	6.3%
Hamsterley	Durham & Darlington	MHSOP	15	94.7%	104.1%	117.5%	125.5%	2710.99	13.9%
Oak Ward	Durham & Darlington	MHSOP	12	98.6%	100.4%	94.2%	101.9%	455.84	2.9%
Roseberry Wards	Durham & Darlington	MHSOP	15	96.4%	100.5%	97.7%	100.5%	2510.65	15.1%
Talbot Direct Care	Durham & Darlington	MHSOP	1	109.1%	97.5%	138.5%	153.5%	19.25	0.2%
Clover / Ivy	Forensics	Forensic LD	12	94.8%	102.7%	122.2%	174.8%	8692.09	31.8%
Eagle / Osprey	Forensics	Forensic LD	10	88.9%	98.0%	94.5%	98.3%	2437.92	12.9%
Harrier / Hawk	Forensics	Forensic LD	10	85.4%	98.1%	113.5%	122.9%	4021.66	16.7%
Kestrel / Kite.	Forensics	Forensic LD	16	95.4%	96.4%	122.5%	147.9%	5887.99	21.2%
Langley	Forensics	Forensic LD	10	79.4%	99.5%	119.3%	105.4%	1445.00	11.1%
Northdale Centre	Forensics	Forensic LD	12	81.1%	88.5%	122.5%	97.7%	8207.88	28.6%
Oakwood	Forensics	Forensic LD	8	87.9%	100.1%	163.4%	100.0%	505.25	4.1%
Thistle	Forensics	Forensic LD	5	71.3%	99.5%	112.5%	99.3%	1617.85	9.2%
Brambling	Forensics	Forensic MH	13	88.1%	100.7%	102.2%	99.2%	1496.25	9.1%
Jay Ward	Forensics	Forensic MH	5	84.7%	102.2%	102.8%	102.0%	1960.50	12.0%
Lark	Forensics	Forensic MH	15	90.4%	103.3%	104.4%	98.7%	1818.05	11.1%
Linnet Ward	Forensics	Forensic MH	17	80.9%	103.3%	116.8%	110.2%	3114.00	17.7%
Mallard	Forensics	Forensic MH	16	86.6%	103.0%	124.1%	165.4%	6422.00	28.5%
Mandarin	Forensics	Forensic MH	16	83.9%	106.4%	121.9%	125.3%	3237.25	17.3%
Merlin	Forensics	Forensic MH	10	104.3%	92.4%	155.9%	209.8%	9808.37	33.5%

Newtondale	Forensics	Forensic MH	20	86.1%	71.6%	106.1%	123.5%	3805.01	17.3%
Nightingale	Forensics	Forensic MH	16	78.2%	101.1%	98.5%	97.1%	2267.50	14.4%
Sandpiper Ward	Forensics	Forensic MH	8	89.6%	80.3%	117.5%	165.4%	5783.23	22.5%
Swift Ward	Forensics	Forensic MH	10	81.9%	100.1%	114.3%	131.7%	4391.50	21.9%
Fulmar Ward	Forensics	Locked Rehab	12	91.2%	98.3%	113.5%	140.9%	4037.75	19.4%
The Orchards (NY)	North Yorkshire	AMH	10	97.0%	68.0%	78.7%	90.8%	72.00	0.6%
Ayckbourn Danby Ward	North Yorkshire	AMH	11	74.5%	94.5%	106.5%	97.0%	2037.00	14.6%
Ayckbourn Esk Ward	North Yorkshire	AMH	11	77.5%	106.5%	118.3%	96.5%	2037.75	12.8%
Cedar (NY)	North Yorkshire	AMH	18	83.0%	87.8%	108.5%	121.9%	1531.80	7.5%
Ward 15	North Yorkshire	AMH	12	72.0%	100.4%	141.4%	98.6%	3783.86	24.8%
Rowan Lea	North Yorkshire	MHSOP	20	101.0%	109.0%	112.8%	104.8%	777.67	3.5%
Rowan Ward	North Yorkshire	MHSOP	16	89.4%	99.6%	140.6%	133.1%	2253.00	12.4%
Springwood	North Yorkshire	MHSOP	14	68.0%	101.7%	132.4%	159.9%	2014.51	10.1%
Ward 14	North Yorkshire	MHSOP	10	71.5%	101.3%	124.3%	102.4%	341.20	2.3%
Kirkdale	Teesside	Locked Rehab	16	86.3%	104.1%	103.5%	102.7%	1084.50	5.9%
Bedale Ward	Teesside	AMH	10	82.0%	110.7%	190.7%	117.5%	6504.00	29.9%
Bilsdale	Teesside	AMH	14	88.2%	105.6%	127.0%	98.5%	1036.00	6.5%
Bransdale	Teesside	AMH	14	85.1%	99.5%	141.8%	133.9%	5371.00	29.9%
Lincoln Ward	Teesside	AMH	20	101.7%	98.8%	100.9%	108.7%	1119.25	6.3%
Overdale	Teesside	AMH	18	84.9%	100.7%	112.7%	108.6%	2218.75	13.8%
Stockdale	Teesside	AMH	18	97.5%	99.3%	107.1%	104.4%	2391.33	15.1%
Baysdale	Teesside	CYPS	6	108.4%	104.0%	106.9%	99.7%	1106.95	7.5%
Newberry Centre	Teesside	CYPS	14	85.7%	103.2%	122.4%	125.0%	2903.89	12.5%
The Evergreen Centre	Teesside	CYPS	16	94.0%	105.5%	129.6%	108.3%	1585.25	5.3%
Westwood Centre	Teesside	CYPS	12	103.6%	103.3%	143.2%	188.3%	5598.67	17.2%
Aysgarth	Teesside	LD	6	116.5%	101.5%	114.7%	100.8%	2634.41	19.2%
Bankfields Court	Teesside	LD		81.6%	99.3%	103.2%	96.8%	3922.47	9.9%
Bankfields Court Flats	Teesside	LD	6	102.7%	114.3%	83.4%	97.9%	195.09	10.2%
Bankfields Court Unit 2	Teesside	LD	5	115.9%	109.2%	100.2%	115.2%	2695.46	19.6%
Bankfields Court Unit 3	Teesside	LD	6	77.1%	100.0%	108.7%	91.9%	109.99	4.7%
Bankfields Court Unit 4	Teesside	LD	6	98.1%	109.1%	95.2%	92.2%	128.25	6.2%
The Lodge	Teesside	LD	1	96.9%	82.3%	88.8%	107.8%	134.00	7.8%
Lustrum Vale	Teesside	MHSOP	20	83.6%	100.9%	123.3%	107.3%	2267.13	13.3%
Westerdale North	Teesside	MHSOP	18	98.6%	101.2%	130.9%	107.2%	1087.00	6.5%
Westerdale South	Teesside	MHSOP	14	104.1%	99.6%	127.0%	125.2%	9695.79	37.6%

Wingfield	Teesside	MHSOP	10	**95.6%**	**102.9%**	**113.1%**	**103.2%**	1542.50	**10.0%**
Acomb Garth	York & Selby	MHSOP	14	**83.7%**	**111.9%**	**92.4%**	**199.2%**	318.20	**2.4%**
Ebor Ward	York & Selby	AMH	12	**94.2%**	**97.1%**	**95.5%**	**111.0%**	778.00	**4.7%**
Minster Ward	York & Selby	AMH	12	**112.2%**	**104.8%**	**95.0%**	**99.8%**	2409.00	**15.2%**
Oak Rise	York & Selby	LD	8	**107.8%**	**92.8%**	**79.6%**	**95.6%**	1414.59	**6.5%**
Meadowfields	York & Selby	MHSOP	14	**82.2%**	**91.9%**	**83.7%**	**104.0%**	3767.40	**20.6%**
Worsley Court	York & Selby	MHSOP	14	**68.8%**	**99.6%**	**85.2%**	**164.0%**	93.50	**3.8%**
Cherry Tree House	York & Selby	MHSOP	18	**98.7%**	**94.6%**	**88.3%**	**114.1%**	701.00	**3.6%**
Total			913	**91.2%**	**98.5%**	**115.1%**	**116.7%**	193196.19	**14.8%**

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

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

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

Ward Name	Locality	Speciality	Bed Numbers (May)	Overtime		Agency		Bank		Maternity		Sickness		Vacancies	
				Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours	Hours	% loss against Actual Hours
Cedar	Durham & Darlington	AMH	10	803.03	3.1%	0.0	0.0%	8679.6	33.6%	78.7	0.3%	1859.3	7.2%	217.5	0.8%
Elm Ward	Durham & Darlington	AMH	20	639.22	3.9%	0.0	0.0%	4171.3	25.3%	1108.5	6.7%	2293.0	13.9%	765.0	4.6%
Farnham Ward	Durham & Darlington	AMH	20	448.91	2.6%	0.0	0.0%	930.0	5.4%	0.0	0.0%	865.0	5.0%	315.0	1.8%
Maple	Durham & Darlington	AMH	20	889.82	5.6%	0.0	0.0%	1995.1	12.6%	0.0	0.0%	1961.3	12.4%	397.5	2.5%
Primrose Lodge	Durham & Darlington	AMH	15	604.48	4.1%	0.0	0.0%	1303.5	8.7%	0.0	0.0%	1606.0	10.8%	412.5	2.8%
Tunstall Ward	Durham & Darlington	AMH	20	545.32	3.1%	0.0	0.0%	288.0	1.6%	0.0	0.0%	1522.0	8.5%	600.0	3.4%
Willow Ward	Durham & Darlington	AMH	15	690.33	4.1%	0.0	0.0%	1554.8	9.2%	0.0	0.0%	3027.5	18.0%	322.5	1.9%
Holly	Durham & Darlington	CAMHS	4	709.21	8.7%	0.0	0.0%	865.2	10.6%	0.0	0.0%	80.0	1.0%	487.5	5.9%
Birch Ward	Durham & Darlington	ED	15	697.58	3.6%	0.0	0.0%	4892.0	25.3%	37.3	0.2%	1542.6	8.0%	1890.0	9.8%
Bek-Ramsey Wards	Durham & Darlington	LD	11	1246.66	4.8%	0.0	0.0%	994.7	3.8%	675.0	2.6%	645.8	2.5%	851.3	3.3%
Ceddesfeld	Durham & Darlington	MHSOP	15	446.84	2.3%	0.0	0.0%	1206.2	6.3%	0.0	0.0%	1352.0	7.1%	270.0	1.4%
Hamsterley	Durham & Darlington	MHSOP	15	876.93	4.5%	0.0	0.0%	2711.0	13.9%	540.0	2.8%	1438.0	7.4%	270.0	1.4%
Oak Ward	Durham & Darlington	MHSOP	12	253.3	1.6%	0.0	0.0%	455.8	2.9%	0.0	0.0%	796.5	5.0%	93.8	0.6%
Roseberry Wards	Durham & Darlington	MHSOP	15	183.38	1.1%	0.0	0.0%	2510.7	15.1%	132.0	0.8%	1143.4	6.9%	510.0	3.1%
Talbot Direct Care	Durham & Darlington	CAMHS	1	404.64	3.2%	0.0	0.0%	19.3	0.2%	0.0	0.0%	234.0	1.8%	1057.5	8.3%
Clover / Ivy	Forensics	Forensic LD	12	1159.17	4.2%	0.0	0.0%	8692.1	31.8%	791.3	2.9%	740.2	2.7%	1346.3	4.9%
Eagle / Osprey	Forensics	Forensic LD	10	296.84	1.6%	0.0	0.0%	2437.9	12.9%	1376.3	7.3%	1993.8	10.5%	701.3	3.7%
Harrier / Hawk	Forensics	Forensic LD	10	897.01	3.7%	495.0	2.1%	4021.7	16.7%	0.0	0.0%	1863.7	7.7%	1455.0	6.0%
Kestrel / Kite.	Forensics	Forensic LD	16	845.62	3.1%	76.0	0.3%	5888.0	21.2%	1462.5	5.3%	1793.3	6.5%	652.5	2.4%
Langley	Forensics	Forensic LD	10	244.5	1.9%	0.0	0.0%	1445.0	11.1%	0.0	0.0%	569.3	4.4%	303.8	2.3%
Northdale Centre	Forensics	Forensic LD	12	1166.66	4.1%	686.3	2.4%	8207.9	28.6%	0.0	0.0%	2780.0	9.7%	1166.3	4.1%
Oakwood	Forensics	Forensic LD	8	231.25	1.9%	0.0	0.0%	505.3	4.1%	0.0	0.0%	1068.5	8.6%	15.0	0.1%
Thistle	Forensics	Forensic LD	5	683.76	3.9%	0.0	0.0%	1617.9	9.2%	0.0	0.0%	156.8	0.9%	2182.5	12.4%
Brambling	Forensics	Forensic MH	13	161	1.0%	0.0	0.0%	1496.3	9.1%	1076.3	6.5%	1040.3	6.3%	453.8	2.8%
Jay Ward	Forensics	Forensic MH	5	530.75	3.3%	0.0	0.0%	1960.5	12.0%	67.5	0.4%	773.2	4.8%	1556.3	9.6%
Lark	Forensics	Forensic MH	15	348.5	2.1%	0.0	0.0%	1818.1	11.1%	975.0	6.0%	1212.4	7.4%	1387.5	8.5%
Linnet Ward	Forensics	Forensic MH	17	405.5	2.3%	0.0	0.0%	3114.0	17.7%	993.8	5.6%	745.6	4.2%	1601.3	9.1%
Mallard	Forensics	Forensic MH	16	353.92	1.6%	0.0	0.0%	6422.0	28.5%	885.0	3.9%	1761.5	7.8%	671.3	3.0%
Mandarin	Forensics	Forensic MH	16	1198.5	6.4%	0.0	0.0%	3237.3	17.3%	457.5	2.4%	793.5	4.2%	1830.0	9.8%

Merlin	Forensics	Forensic MH	10	903.73	3.1%	0.0	0.0%	9808.4	33.5%	187.5	0.6%	435.4	1.5%	2396.3	8.2%
Newtondale	Forensics	Forensic MH	20	587.9	2.7%	0.0	0.0%	3805.0	17.3%	821.3	3.7%	948.6	4.3%	2100.0	9.5%
Nightingale	Forensics	Forensic MH	16	518.42	3.3%	0.0	0.0%	2267.5	14.4%	3677.5	23.3%	136.7	0.9%	1057.5	6.7%
Sandpiper Ward	Forensics	Forensic MH	8	646.93	2.5%	0.0	0.0%	5783.2	22.5%	525.0	2.0%	389.0	1.5%	1597.5	6.2%
Swift Ward	Forensics	Forensic MH	10	539.83	2.7%	0.0	0.0%	4391.5	21.9%	998.3	5.0%	2417.8	12.0%	678.8	3.4%
Fulmar Ward	Forensics	Locked Rehab	12	197.61	0.9%	0.0	0.0%	4037.8	19.4%	1526.3	7.3%	851.3	4.1%	840.0	4.0%
The Orchards (NY)	North Yorkshire	AMH	10	715.1	6.1%	0.0	0.0%	72.0	0.6%	981.0	8.3%	1332.8	11.3%	187.5	1.6%
Ayckbourn Danby Ward	North Yorkshire	AMH	11	765.42	5.5%	0.0	0.0%	2037.0	14.6%	0.0	0.0%	681.5	4.9%	1991.3	14.3%
Ayckbourn Esk Ward	North Yorkshire	AMH	11	409.75	2.6%	0.0	0.0%	2037.8	12.8%	495.0	3.1%	405.7	2.5%	1515.0	9.5%
Cedar (NY)	North Yorkshire	AMH	18	1367.4	6.7%	3768.5	18.6%	1531.8	7.5%	600.0	3.0%	708.4	3.5%	3570.0	17.6%
Ward 15	North Yorkshire	AMH	12	429.87	2.8%	0.0	0.0%	3783.9	24.8%	780.5	5.1%	1614.9	10.6%	435.0	2.9%
Rowan Lea	North Yorkshire	MHSOP	20	1133.47	5.1%	0.0	0.0%	777.7	3.5%	1527.5	6.9%	1251.3	5.7%	187.5	0.8%
Rowan Ward	North Yorkshire	MHSOP	16	694.6	3.8%	1858.5	10.2%	2253.0	12.4%	1814.5	10.0%	1508.8	8.3%	476.3	2.6%
Springwood	North Yorkshire	MHSOP	14	1052.87	5.3%	2383.5	11.9%	2014.5	10.1%	0.0	0.0%	771.4	3.9%	1612.5	8.1%
Ward 14	North Yorkshire	MHSOP	10	822.5	5.5%	0.0	0.0%	341.2	2.3%	0.0	0.0%	857.5	5.7%	307.5	2.1%
Kirkdale	Teesside		16	254.25	1.4%	0.0	0.0%	1084.5	5.9%	0.0	0.0%	1035.5	5.6%	1507.5	8.2%
Bedale Ward	Teesside	AMH	10	913.5	4.2%	0.0	0.0%	6504.0	29.9%	0.0	0.0%	980.5	4.5%	1807.5	8.3%
Bilsdale	Teesside	AMH	14	726.75	4.6%	0.0	0.0%	1036.0	6.5%	0.0	0.0%	596.5	3.8%	720.0	4.5%
Bransdale	Teesside	AMH	14	388.75	2.2%	0.0	0.0%	5371.0	29.9%	0.0	0.0%	1538.8	8.6%	1803.8	10.0%
Lincoln Ward	Teesside	AMH	20	290.6	1.6%	0.0	0.0%	1119.3	6.3%	0.0	0.0%	1232.5	6.9%	1368.8	7.6%
Overdale	Teesside	AMH	18	368	2.3%	0.0	0.0%	2218.8	13.8%	964.5	6.0%	1067.3	6.6%	975.0	6.0%
Stockdale	Teesside	AMH	18	651.75	4.1%	0.0	0.0%	2391.3	15.1%	1050.0	6.6%	340.5	2.1%	911.3	5.7%
Baysdale	Teesside	CAMHS	6	1266.85	8.5%	0.0	0.0%	1107.0	7.5%	1680.0	11.3%	274.7	1.9%	656.3	4.4%
Newberry Centre	Teesside	CAMHS T4	14	991.91	4.3%	0.0	0.0%	2903.9	12.5%	660.0	2.8%	2192.8	9.5%	6011.3	25.9%
The Evergreen Centre	Teesside	CAMHS T4	16	714.75	2.4%	0.0	0.0%	1585.3	5.3%	1275.0	4.3%	505.4	1.7%	615.0	2.1%
Westwood Centre	Teesside	CAMHS T4	12	2694.21	8.3%	0.0	0.0%	5598.7	17.2%	1548.0	4.7%	1339.3	4.1%	975.0	3.0%
Aysgarth	Teesside	LD	6	547.5	4.0%	0.0	0.0%	2634.4	19.2%	285.0	2.1%	1295.5	9.5%	517.5	3.8%
Bankfields Court	Teesside	LD		1668.12	4.2%	0.0	0.0%	3922.5	9.9%	2430.0	6.1%	2773.3	7.0%	5178.8	13.0%
Bankfields Court Flats	Teesside	LD	6	104.84	5.5%	0.0	0.0%	195.1	10.2%	0.0	0.0%	353.0	18.4%	0.0	0.0%
Bankfields Court Unit 2	Teesside	LD	5	1395.21	10.2%	0.0	0.0%	2695.5	19.6%	935.0	6.8%	927.7	6.8%	510.0	3.7%
Bankfields Court Unit 3	Teesside	LD	6	158.17	6.8%	0.0	0.0%	110.0	4.7%	0.0	0.0%	0.0	0.0%	0.0	0.0%
Bankfields Court Unit 4	Teesside	LD	6	212.17	10.3%	0.0	0.0%	128.3	6.2%	0.0	0.0%	0.0	0.0%	0.0	0.0%
The Lodge	Teesside	LD	1	88.17	5.1%	0.0	0.0%	134.0	7.8%	0.0	0.0%	0.0	0.0%	0.0	0.0%
Lustrum Vale	Teesside	MHSOP	20	148.55	0.9%	0.0	0.0%	2267.1	13.3%	0.0	0.0%	1963.3	11.5%	1121.3	6.6%
Westerdale North	Teesside	MHSOP	18	789.42	4.7%	0.0	0.0%	1087.0	6.5%	241.5	1.4%	1378.5	8.3%	701.3	4.2%
Westerdale South	Teesside	MHSOP	14	88.3	0.3%	0.0	0.0%	9695.8	37.6%	1576.8	6.1%	1543.7	6.0%	491.3	1.9%
Wingfield	Teesside	MHSOP	10	186.66	1.2%	0.0	0.0%	1542.5	10.0%	1070.5	6.9%	80.0	0.5%	510.0	3.3%

Acomb Garth	York & Selby	MHSOP	14	361	2.7%	4639.5	34.7%	318.2	2.4%	60.0	0.4%	732.0	5.5%	1065.0	8.0%
Ebor Ward	York & Selby	AMH	12	858.05	5.1%	2563	15.3%	778.0	4.7%	11.5	0.1%	992.5	5.9%	1893.8	11.3%
Minster Ward	York & Selby	AMH	12	1047.24	6.6%	945.5	6.0%	2409.0	15.2%	690.8	4.3%	894.5	5.6%	1642.5	10.3%
Oak Rise	York & Selby	LD	8	545.54	2.5%	737	3.4%	1414.6	6.5%	960.0	4.4%	5670.4	26.0%	941.3	4.3%
Meadowfields	York & Selby	MHSOP	14	102	0.6%	1630.5	8.9%	3767.4	20.6%	1813.5	9.9%	2308.5	12.6%	1008.8	5.5%
Worsley Court	York & Selby	MHSOP	14	11	0.5%	648	26.6%	93.5	3.8%	165.0	6.8%	572.5	23.5%	468.8	19.2%
Cherry Tree House	York & Selby	MHSOP	18	854.5	4.4%	306.5	1.6%	701.0	3.6%	547.5	2.8%	479.2	2.4%	1815.0	9.3%

	Green	Amber	Red
Agency	0 - 2.9%	3- 3.9%	4% and over
Bank Usage	0 - 19.9%	20 - 24.9%	25% and over
Maternity	0 - 1.9%	2 - 4.9%	5% and over
Sickness	0 - 1.9%	2 - 4.9%	5% and over
Vacancies	0 - 4.9%	5 - 9.9%	10% and over

Quality Indicators - 6 Month Total

Appendix 5

Ward Name	Locality	Speciality	Bed Numbers (MAY)	Bank Usage vs Actual Hours		Quality Indicators					Incidents of Restraints				Registered Average %		Unregistered Average %	
				Hours	% against Actual Hours	Number of SIs	Number of Level 4 Incidents	Number of Level 3 (Self-Harm) Incidents	Number of Complaints	Number of PALS	Number of Incidents	Number of PRO Restraints Used	Number of Other Restraints Used	Total Number of Restraints Used	Day	Night	Day	Night
Cedar	Durham & Darlington	AMH	10	8679.6	33.6%				1	1	105	6	171	177	102.2%	100.6%	189.1%	160.0%
Elm Ward	Durham & Darlington	AMH	20	4171.3	25.3%			1	3	9	34	1	48	49	97.6%	101.2%	109.1%	115.6%
Farnham Ward	Durham & Darlington	AMH	20	930.0	5.4%				2	5	10		16	16	129.5%	102.4%	103.1%	101.7%
Maple	Durham & Darlington	AMH	20	1995.1	12.6%			1		5	28		37	37	88.6%	98.9%	99.8%	107.0%
Primrose Lodge	Durham & Darlington	AMH	15	1303.5	8.7%					2	1		1	1	52.2%	100.6%	128.6%	100.0%
Tunstall Ward	Durham & Darlington	AMH	20	288.0	1.6%				1	6	6	2	5	7	112.9%	117.0%	111.5%	101.4%
Willow Ward	Durham & Darlington	AMH	15	1554.8	9.2%					1	8	1	7	8	94.3%	99.0%	153.1%	102.0%
Holly	Durham & Darlington	CAMHS	4	865.2	10.6%						3		3	3	149.8%	117.1%	126.1%	133.9%
Birch Ward	Durham & Darlington	ED	15	4892.0	25.3%				1	3	4		5	5	97.1%	97.2%	106.4%	111.5%
Bek-Ramsey Wards	Durham & Darlington	LD	11	994.7	3.8%						74	2	92	94	109.0%	100.5%	124.2%	103.2%
Ceddesfeld	Durham & Darlington	MHSOP	15	1206.2	6.3%	1	1			1	29		45	45	95.9%	100.0%	115.9%	102.5%
Hamsterley	Durham & Darlington	MHSOP	15	2711.0	13.9%	2	2				17		23	23	94.7%	104.1%	117.5%	125.5%
Oak Ward	Durham & Darlington	MHSOP	12	455.8	2.9%			2		3					98.6%	100.4%	94.2%	101.9%
Roseberry Wards	Durham & Darlington	MHSOP	15	2510.7	15.1%					1	2		2	2	96.4%	100.5%	97.7%	100.5%
Talbot Direct Care	Durham & Darlington	CAMHS	1	19.3	0.2%										109.1%	97.5%	138.5%	153.5%
Clover / Ivy	Forensics	Forensic LD	12	8692.1	31.8%			2		4	75		147	147	94.8%	102.7%	122.2%	174.8%
Eagle / Osprey	Forensics	Forensic LD	10	2437.9	12.9%					1	1		1	1	88.9%	98.0%	94.5%	98.3%
Harrier / Hawk	Forensics	Forensic LD	10	4021.7	16.7%				2	11	20	1	34	35	85.4%	98.1%	113.5%	122.9%
Kestrel / Kite.	Forensics	Forensic LD	16	5888.0	21.2%						79	2	165	167	95.4%	96.4%	122.5%	147.9%

Langley	Forensics	Forensic LD	10	1445.0	11.1%					3					79.4%	99.5%	119.3%	105.4%
Northdale Centre	Forensics	Forensic LD	12	8207.9	28.6%				2	20	8		16	16	81.1%	88.5%	122.5%	97.7%
Oakwood	Forensics	Forensic LD	8	505.3	4.1%										87.9%	100.1%	163.4%	100.0%
Thistle	Forensics	Forensic LD	5	1617.9	9.2%					4	21		54	54	71.3%	99.5%	112.5%	99.3%
Brambling	Forensics	Forensic MH	13	1496.3	9.1%			3		2	46		68	68	88.1%	100.7%	102.2%	99.2%
Jay Ward	Forensics	Forensic MH	5	1960.5	12.0%					1	7	1	10	11	84.7%	102.2%	102.8%	102.0%
Lark	Forensics	Forensic MH	15	1818.1	11.1%				1	7					90.4%	103.3%	104.4%	98.7%
Linnet Ward	Forensics	Forensic MH	17	3114.0	17.7%					2	17		26	26	80.9%	103.3%	116.8%	110.2%
Mallard	Forensics	Forensic MH	16	6422.0	28.5%						9		9	9	86.6%	103.0%	124.1%	165.4%
Mandarin	Forensics	Forensic MH	16	3237.3	17.3%				1	12	1		1	1	83.9%	106.4%	121.9%	125.3%
Merlin	Forensics	Forensic MH	10	9808.4	33.5%					3	147	7	198	205	104.3%	92.4%	155.9%	209.8%
Newtondale	Forensics	Forensic MH	20	3805.0	17.3%					2	3		9	9	86.1%	71.6%	106.1%	123.5%
Nightingale	Forensics	Forensic MH	16	2267.5	14.4%					1	2		2	2	78.2%	101.1%	98.5%	97.1%
Sandpiper Ward	Forensics	Forensic MH	8	5783.2	22.5%			1	1	5	544	37	1378	1415	89.6%	80.3%	117.5%	165.4%
Swift Ward	Forensics	Forensic MH	10	4391.5	21.9%			1			73		124	124	81.9%	100.1%	114.3%	131.7%
Fulmar Ward	Forensics	Locked Rehab	12	4037.8	19.4%			3		2	110		173	173	91.2%	98.3%	113.5%	140.9%
The Orchards (NY)	North Yorkshire	AMH	10	72.0	0.6%										97.0%	68.0%	78.7%	90.8%
Ayckbourn Danby Ward	North Yorkshire	AMH	11	2037.0	14.6%				1		25		39	39	74.5%	94.5%	106.5%	97.0%
Ayckbourn Esk Ward	North Yorkshire	AMH	11	2037.8	12.8%			3	3	6	43	1	52	53	77.5%	106.5%	118.3%	96.5%
Cedar (NY)	North Yorkshire	AMH	18	1531.8	7.5%	2	4	1		5	42	1	58	59	83.0%	87.8%	108.5%	121.9%
Ward 15	North Yorkshire	AMH	12	3783.9	24.8%					4	6		8	8	72.0%	100.4%	141.4%	98.6%
Rowan Lea	North Yorkshire	MHSOP	20	777.7	3.5%	1	1		3	4	60		93	93	101.0%	109.0%	112.8%	104.8%
Rowan Ward	North Yorkshire	MHSOP	16	2253.0	12.4%				2	1	47		87	87	89.4%	99.6%	140.6%	133.1%
Springwood	North Yorkshire	MHSOP	14	2014.5	10.1%	1	1				191		227	227	68.0%	101.7%	132.4%	159.9%
Ward 14	North Yorkshire	MHSOP	10	341.2	2.3%	1	1				18		28	28	71.5%	101.3%	124.3%	102.4%
Kirkdale	Teesside	Locked Rehab	16	1084.5	5.9%						6		7	7	86.3%	104.1%	103.5%	102.7%
Bedale Ward	Teesside	AMH	10	6504.0	29.9%				2	3	74	5	128	133	82.0%	110.7%	190.7%	117.5%
Bilsdale	Teesside	AMH	14	1036.0	6.5%					2	5		11	11	88.2%	105.6%	127.0%	98.5%
Bransdale	Teesside	AMH	14	5371.0	29.9%			1	1	12	25	1	42	43	85.1%	99.5%	141.8%	133.9%
Lincoln Ward	Teesside	AMH	20	1119.3	6.3%			1	2	1	27		37	37	101.7%	98.8%	100.9%	108.7%
Overdale	Teesside	AMH	18	2218.8	13.8%	1		2	1	3	10		14	14	84.9%	100.7%	112.7%	108.6%
Stockdale	Teesside	AMH	18	2391.3	15.1%				1	4	18	1	30	31	97.5%	99.3%	107.1%	104.4%
Baysdale	Teesside	CAMHS	6	1107.0	7.5%										108.4%	104.0%	106.9%	99.7%
Newberry Centre	Teesside	CAMHS T4	14	2903.9	12.5%			1	1	3	284	4	469	473	85.7%	103.2%	122.4%	125.0%

The Evergreen Centre	Teesside	CAMHS T4	16	1585.3	5.3%			1			404		597	597	94.0%	105.5%	129.6%	108.3%
Westwood Centre	Teesside	CAMHS T4	12	5598.7	17.2%			4		3	246	5	433	438	103.6%	103.3%	143.2%	188.3%
Aysgarth	Teesside	LD	6	2634.4	19.2%										116.5%	101.5%	114.7%	100.8%
Bankfields Court	Teesside	LD		3922.5	9.9%										81.6%	99.3%	103.2%	96.8%
The Lodge	Teesside	LD	1	134.0	7.8%										96.9%	82.3%	88.8%	107.8%
Lustrum Vale	Teesside	MHSOP	20	2267.1	13.3%	1	1				10		14	14	83.6%	100.9%	123.3%	107.3%
Westerdale North	Teesside	MHSOP	18	1087.0	6.5%						8		9	9	98.6%	101.2%	130.9%	107.2%
Westerdale South	Teesside	MHSOP	14	9695.8	37.6%	1					18		31	31	104.1%	99.6%	127.0%	125.2%
Wingfield	Teesside	MHSOP	10	1542.5	10.0%	1	1								95.6%	102.9%	113.1%	103.2%
Acomb Garth	York & Selby	MHSOP	14	318.2	2.4%										83.7%	111.9%	92.4%	199.2%
Ebor Ward	York & Selby	AMH	12	778.0	4.7%			1			31		38	38	94.2%	97.1%	95.5%	111.0%
Minster Ward	York & Selby	AMH	12	2409.0	15.2%					4	18	2	26	28	112.2%	104.8%	95.0%	99.8%
Oak Rise	York & Selby	LD	8	1414.6	6.5%						9		11	11	107.8%	92.8%	79.6%	95.6%
Meadowfields	York & Selby	MHSOP	14	3767.4	20.6%					1	26		32	32	82.2%	91.9%	83.7%	104.0%
Worsley Court	York & Selby	MHSOP	14	93.5	3.8%					2	4		5	5	68.8%	99.6%	85.2%	164.0%
Cherry Tree House	York & Selby	MHSOP	18	701.0	3.6%			1	1	1	26		32	32	98.7%	94.6%	88.3%	114.1%

Quality Indicators - 6 Month Total

Appendix 6

Ward Name	Locality	Speciality	Bed Numbers (May)	Safe Nursing Indicators											
				Falls resulting in significant harm	Pressure Ulcers	Medication Errors	Missed Breaks	Staffing Fill Rate - Day - Registered Nurses	Staffing Fill Rate - Night - Registered Nurses	Staffing Fill Rate - Day - Unregistered Nurses	Staffing Fill Rate - Night - Unregistered Nurses	Bank Usage vs Actual Hours	Agency Usage vs Actual Hours	Overtime Usage vs Actual Hours	Mandatory Training (May 17)
Cedar	Durham & Darlington	AMH	10		1	3	2	102.2%	100.6%	189.1%	160.0%	33.6%	0.0%	3.1%	87.45%
Elm Ward	Durham & Darlington	AMH	20			12	18	97.6%	101.2%	109.1%	115.6%	25.3%	0.0%	3.9%	74.73%
Farnham Ward	Durham & Darlington	AMH	20			5	33	129.5%	102.4%	103.1%	101.7%	5.4%	0.0%	2.6%	83.10%
Maple	Durham & Darlington	AMH	20			7	37	88.6%	98.9%	99.8%	107.0%	12.6%	0.0%	5.6%	68.77%
Primrose Lodge	Durham & Darlington	AMH	15			1	16	52.2%	100.6%	128.6%	100.0%	8.7%	0.0%	4.1%	82.94%
Tunstall Ward	Durham & Darlington	AMH	20			4	52	112.9%	117.0%	111.5%	101.4%	1.6%	0.0%	3.1%	85.59%
Willow Ward	Durham & Darlington	AMH	15			8	10	94.3%	99.0%	153.1%	102.0%	9.2%	0.0%	4.1%	82.69%
Holly	Durham & Darlington	CAMHS	4				42	149.8%	117.1%	126.1%	133.9%	10.6%	0.0%	8.7%	88.82%
Birch Ward	Durham & Darlington	ED	15			8	1	97.1%	97.2%	106.4%	111.5%	25.3%	0.0%	3.6%	76.52%
Bek-Ramsey Wards	Durham & Darlington	LD	11			2	9	109.0%	100.5%	124.2%	103.2%	3.8%	0.0%	4.8%	92.13%
Ceddesfeld	Durham & Darlington	MHSOP	15	1		3	10	95.9%	100.0%	115.9%	102.5%	6.3%	0.0%	2.3%	78.90%
Hamsterley	Durham & Darlington	MHSOP	15	2		1	73	94.7%	104.1%	117.5%	125.5%	13.9%	0.0%	4.5%	76.01%
Oak Ward	Durham & Darlington	MHSOP	12			5	2	98.6%	100.4%	94.2%	101.9%	2.9%	0.0%	1.6%	82.05%
Roseberry Wards	Durham & Darlington	MHSOP	15			1	41	96.4%	100.5%	97.7%	100.5%	15.1%	0.0%	1.1%	89.03%
Talbot Direct Care	Durham & Darlington	CAMHS	1			1		109.1%	97.5%	138.5%	153.5%	0.2%	0.0%	3.2%	
Clover / Ivy	Forensics	Forensic LD	12			12	41	94.8%	102.7%	122.2%	174.8%	31.8%	0.0%	4.2%	69.23%
Eagle / Osprey	Forensics	Forensic LD	10				11	88.9%	98.0%	94.5%	98.3%	12.9%	0.0%	1.6%	89.97%
Harrier / Hawk	Forensics	Forensic LD	10			6	65	85.4%	98.1%	113.5%	122.9%	16.7%	2.1%	3.7%	96.74%
Kestrel / Kite.	Forensics	Forensic LD	16			10	13	95.4%	96.4%	122.5%	147.9%	21.2%	0.3%	3.1%	78.59%
Langley	Forensics	Forensic LD	10			2	7	79.4%	99.5%	119.3%	105.4%	11.1%	0.0%	1.9%	90.50%
Northdale Centre	Forensics	Forensic LD	12			5	34	81.1%	88.5%	122.5%	97.7%	28.6%	2.4%	4.1%	83.48%
Oakwood	Forensics	Forensic LD	8			3	6	87.9%	100.1%	163.4%	100.0%	4.1%	0.0%	1.9%	88.94%
Thistle	Forensics	Forensic LD	5			3	16	71.3%	99.5%	112.5%	99.3%	9.2%	0.0%	3.9%	98.27%

Brambling	Forensics	Forensic MH	13			14	12	88.1%	100.7%	102.2%	99.2%	9.1%	0.0%	1.0%	92.86%
Jay Ward	Forensics	Forensic MH	5			4	18	84.7%	102.2%	102.8%	102.0%	12.0%	0.0%	3.3%	87.32%
Lark	Forensics	Forensic MH	15			9	20	90.4%	103.3%	104.4%	98.7%	11.1%	0.0%	2.1%	86.41%
Linnet Ward	Forensics	Forensic MH	17			10	27	80.9%	103.3%	116.8%	110.2%	17.7%	0.0%	2.3%	86.98%
Mallard	Forensics	Forensic MH	16		1	5	38	86.6%	103.0%	124.1%	165.4%	28.5%	0.0%	1.6%	87.22%
Mandarin	Forensics	Forensic MH	16			2	31	83.9%	106.4%	121.9%	125.3%	17.3%	0.0%	6.4%	86.24%
Merlin	Forensics	Forensic MH	10			4	53	104.3%	92.4%	155.9%	209.8%	33.5%	0.0%	3.1%	91.42%
Newtondale	Forensics	Forensic MH	20			11	35	86.1%	71.6%	106.1%	123.5%	17.3%	0.0%	2.7%	76.35%
Nightingale	Forensics	Forensic MH	16			7	7	78.2%	101.1%	98.5%	97.1%	14.4%	0.0%	3.3%	90.07%
Sandpiper Ward	Forensics	Forensic MH	8			7	67	89.6%	80.3%	117.5%	165.4%	22.5%	0.0%	2.5%	85.59%
Swift Ward	Forensics	Forensic MH	10			16	23	81.9%	100.1%	114.3%	131.7%	21.9%	0.0%	2.7%	87.83%
Fulmar Ward	Forensics	Locked Rehab	12			4	57	91.2%	98.3%	113.5%	140.9%	19.4%	0.0%	0.9%	90.39%
The Orchards (NY)	North Yorkshire	AMH	10				17	97.0%	68.0%	78.7%	90.8%	0.6%	0.0%	6.1%	90.55%
Ayckbourn Danby Ward	North Yorkshire	AMH	11			2	4	74.5%	94.5%	106.5%	97.0%	14.6%	0.0%	5.5%	85.45%
Ayckbourn Esk Ward	North Yorkshire	AMH	11			1	4	77.5%	106.5%	118.3%	96.5%	12.8%	0.0%	2.6%	86.26%
Cedar (NY)	North Yorkshire	AMH	18			7	104	83.0%	87.8%	108.5%	121.9%	7.5%	18.6%	6.7%	78.40%
Ward 15	North Yorkshire	AMH	12			1	11	72.0%	100.4%	141.4%	98.6%	24.8%	0.0%	2.8%	79.61%
Rowan Lea	North Yorkshire	MHSOP	20	1		4	55	101.0%	109.0%	112.8%	104.8%	3.5%	0.0%	5.1%	81.15%
Rowan Ward	North Yorkshire	MHSOP	16			9	30	89.4%	99.6%	140.6%	133.1%	12.4%	10.2%	3.8%	74.09%
Springwood	North Yorkshire	MHSOP	14	1		1	7	68.0%	101.7%	132.4%	159.9%	10.1%	11.9%	5.3%	80.62%
Ward 14	North Yorkshire	MHSOP	10	1		2	24	71.5%	101.3%	124.3%	102.4%	2.3%	0.0%	5.5%	89.74%
Kirkdale	Teesside	Locked Rehab	16			5	15	86.3%	104.1%	103.5%	102.7%	5.9%	0.0%	1.4%	92.43%
Bedale Ward	Teesside	AMH	10			3	27	82.0%	110.7%	190.7%	117.5%	29.9%	0.0%	4.2%	90.32%
Bilsdale	Teesside	AMH	14			2	10	88.2%	105.6%	127.0%	98.5%	6.5%	0.0%	4.6%	92.31%
Bransdale	Teesside	AMH	14			13	11	85.1%	99.5%	141.8%	133.9%	29.9%	0.0%	2.2%	93.94%
Lincoln Ward	Teesside	AMH	20			5	13	101.7%	98.8%	100.9%	108.7%	6.3%	0.0%	1.6%	87.38%
Overdale	Teesside	AMH	18			11	14	84.9%	100.7%	112.7%	108.6%	13.8%	0.0%	2.3%	77.58%
Stockdale	Teesside	AMH	18			4	28	97.5%	99.3%	107.1%	104.4%	15.1%	0.0%	4.1%	95.41%
Baysdale	Teesside	CAMHS	6			6	43	108.4%	104.0%	106.9%	99.7%	7.5%	0.0%	8.5%	89.34%
Newberry Centre	Teesside	CAMHS T4	14			8	237	85.7%	103.2%	122.4%	125.0%	12.5%	0.0%	4.3%	87.69%
The Evergreen Centre	Teesside	CAMHS T4	16			12	7	94.0%	105.5%	129.6%	108.3%	5.3%	0.0%	2.4%	90.11%
Westwood Centre	Teesside	CAMHS T4	12			13	43	103.6%	103.3%	143.2%	188.3%	17.2%	0.0%	8.3%	89.66%
Aysgarth	Teesside	LD	6			1		116.5%	101.5%	114.7%	100.8%	19.2%	0.0%	4.0%	94.59%
Bankfields Court	Teesside	LD					430	81.6%	99.3%	103.2%	96.8%	9.9%	0.0%	4.2%	76.49%
Bankfields Court Flats	Teesside	LD	6			1		102.7%	114.3%	83.4%	97.9%	10.2%	0.0%	5.5%	83.33%

Bankfields Court Unit 2	Teesside	LD	5			2		115.9%	109.2%	100.2%	115.2%	19.6%	0.0%	10.2%	
Bankfields Court Unit 3	Teesside	LD	6			1		77.1%	100.0%	108.7%	91.9%	4.7%	0.0%	6.8%	
Bankfields Court Unit 4	Teesside	LD	6			5		98.1%	109.1%	95.2%	92.2%	6.2%	0.0%	10.3%	
The Lodge	Teesside	LD	1			1		96.9%	82.3%	88.8%	107.8%	7.8%	0.0%	5.1%	
Lustrum Vale	Teesside	MHSOP	20			5	71	83.6%	100.9%	123.3%	107.3%	13.3%	0.0%	0.9%	87.36%
Westerdale North	Teesside	MHSOP	18			21	49	98.6%	101.2%	130.9%	107.2%	6.5%	0.0%	4.7%	79.18%
Westerdale South	Teesside	MHSOP	14	1		7	68	104.1%	99.6%	127.0%	125.2%	37.6%	0.0%	0.3%	82.88%
Wingfield	Teesside	MHSOP	10	1		10	56	95.6%	102.9%	113.1%	103.2%	10.0%	0.0%	1.2%	92.69%
Acomb Garth	York & Selby	MHSOP	14			5	3	83.7%	111.9%	92.4%	199.2%	2.4%	34.7%	2.7%	
Ebor Ward	York & Selby	AMH	12			10	11	94.2%	97.1%	95.5%	111.0%	4.7%	15.3%	5.1%	73.88%
Minster Ward	York & Selby	AMH	12			6	98	112.2%	104.8%	95.0%	99.8%	15.2%	6.0%	6.6%	77.34%
Oak Rise	York & Selby	LD	8			2	5	107.8%	92.8%	79.6%	95.6%	6.5%	3.4%	2.5%	82.75%
Meadowfields	York & Selby	MHSOP	14		2	23	241	82.2%	91.9%	83.7%	104.0%	20.6%	8.9%	0.6%	89.15%
Worsley Court	York & Selby	MHSOP	14			4		68.8%	99.6%	85.2%	164.0%	3.8%	26.6%	0.5%	11.76%
Cherry Tree House	York & Selby	MHSOP	18			14	3	98.7%	94.6%	88.3%	114.1%	3.6%	1.6%	4.4%	84.91%

STRATEGIC CLINICAL TEAM ESTABLISHMENT REVIEW GUIDANCE

Introduction:

Safe and sustainable staffing is fundamental to good quality care and includes many variables beyond numbers of staff.

Professional judgement is the use of accumulated knowledge and experience to make an informed decision. It takes account of the law, ethics and all other relevant factors. The multidisciplinary team's professional judgement ensures balance, and all teams should be subject to senior clinical oversight. Professional judgement is crucial in establishment reviews when cross-checking data from evidence-based workforce tools with quality and outcome data. This ensures that decisions are not based solely on clinical staff's professional opinion.

Establishment Reviews

The establishment reviews will be conducted as a minimum on an annual basis in a face-to-face meeting between the inpatient clinical team and representatives from the nursing and governance directorate (the review team).

The will enable teams to formally discuss key areas for supporting and underpinning staffing-level decisions for annual and six-monthly staffing reviews. It will support the approach to agreeing clinical staffing requirements based on a person's assessed needs, acuity and risk, helping identify core areas of consideration. The discussion can also be used to highlight areas that identify positive practice and issues for action.

This review is an opportunity to determine whether the current staffing establishment meets service users' needs most productively. A thorough review must be completed at least annually or where a major service change takes place.

Review Team

The review team should include:

- Head of Nursing for respective area
- Modern Matron
- Ward or Team Manager
- Deputy Director of Nursing (Chair)
- Head of Quality Data
- Finance representative

Please note that the review meetings cannot go ahead unless either the Modern Matron or Ward/Team Manager is in attendance.

Preparation

Prior to the meeting taking place an establishment review template (attached at appendix 1) will be pre-populated with the acuity and dependency data obtained from the data collection and subsequent processing utilising the Hurst Tools. In addition information will be gathered in relation to a range of quality and workforce metrics and included within the template.

This data will be made available to the review team no later than 1 week prior to the review taking place.

All information provided in advance of the review meetings should be reviewed by the review team to enable a thorough examination of the information provided during the review meeting itself.

Review Process

The review team will consider all data relating to team activity and discuss required staffing levels. The review template will form the basis of the discussions throughout the review meetings.

A RAG rating will be assigned to each element of the review template which will be used to provide assurance that the review team have cross-referenced the data using evidence-based guidance and presenting a rounded view of staffing requirements to support professional judgements and decisions about delivering high quality, safe care to patients. The discussion will review all budgeted establishments/teams to identify any resource variances.

Following the Review Meetings

After the review meeting a report will be submitted to the director of nursing to make the process transparent and enable team requirements to be included in the final board report. In addition the final report may need to be presented to a number of relevant subcommittees e.g. Workforce, Joint Consultative Committee.

The clinical review team will receive regular feedback as the report is progressed through our internal governance routes.

APPENDIX 1

Establishment Review Template:

Strategic Clinical Team Establishment Review Template

Ward / Team _____ Review Date: _____

Evidence reviewed	RAG	Comments	Action required	Review date
Expectation 1: Right staff				
Administrative support is available				
Benchmark data for an equivalent team				
Team budget meets requirements, including a review of headroom				
Expectation 2: Right skills				
Technology to support team function				
Effective appraisals are conducted				
Mandatory training standard met				
Staff supervision/reflective practice processes in place				
All staff have had an appropriate induction (including temporary staff), including evidence of implementation				
Skill mix data reflects need				
Expectation 3: Right Place and Time				
Care hours per patient day data (inpatient)				
Fill rate data reflects requirement				
Ward environment appropriate				
Staff sickness within trust threshold				
Use of bank/agency/overtime within threshold				
Staff turnover measures				
Shift patterns match patient need				
Therapeutic activity matches person's needs and is consistently delivered				
Quality dashboard trend data				
Escalation process and a review of escalated events				
Dependency/acuity data using evidence-based tools				
Escalation plans in place				
Feedback from regulators				
Patient experience measures				
Student feedback considered				

Staff feedback considered				
Bed occupancy				
Organisational clinical handover standards are met				
Review of Hurst Data Collection				

ITEM NO. 6

FOR GENERAL RELEASE

TRUST BOARD OF DIRECTORS

DATE:	**20/07/2017**
TITLE:	**Update of Essential Standards- Stirling Dementia Design Audit Mental Health Services For Older People (MHSOP) Report**
REPORT OF:	
REPORT FOR:	**Board of Directors**

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

Executive Summary:

Since 2012, Mental Health Services for Older People across the Trust have undertaken audits on in patient wards caring for people with dementia, using the Stirling Dementia Design Audit tool.

The audit tool, which aims to provide dementia services with an understanding of what constitutes a good and safe environment for people with dementia, comprises of 345 standards, of which 118 standards are identified as Essential. It is these 118 Essential standards that the audits have focused upon.

Findings from the initial audits carried out in 2012 and then again in 2013/14 highlighted a number of areas across the localities where compliance against the standards had not been achieved resulting in detailed action plans being developed for each locality.

To review progress against the developed action plans and identify the Trusts level of compliance against the Stirling Essential Standards, a re audit of work across MHSOP organic wards was undertaken between the months of April 2017 and June 2017. The findings of this re audit demonstrated a marked increase in compliance from a baseline of 56% in 2013/14 to 83% in 2017.

All wards audited with the exception of Westerdale South (Teesside) and Springwood (North Yorkshire) demonstrated an increase in compliance; the 2 wards mentioned showed a small decline against the assessment criteria due to issues regarding floor colouring and furniture colourings.

Areas where compliance was not achieved is for the most part due to buildings requiring more large scale estate refurbishments or redecoration all of which has been identified within the planned schedule / lifecycle of work.

Recommendations:

Board is asked to note that:

- Clinical teams will progress their revised action plans following this audit, ensuring that any areas identified which are not manageable within the clinical team are brought to the attention of the appropriate department.
- Monitoring progress through the MHSOP Clinical Audit subgroup with exception reporting to SDG and the relevant QuAG will continue.
- Additional training requirements for clinical and non-clinical staff will be supported.
- The MHSOP Audit programme 2018/19 will include a Trust-wide audit of both the essential and recommended Stirling standards.
- Continuous dialogue and collaborative working between clinical and estate teams to ensure that future changes to estates incorporates the standards as described by the Stirling standards will continue.

1. INTRODUCTION & PURPOSE:

1.1 To provide the Board of Directors with an update in relation to the progress of work associated with the Essential Standards Stirling Dementia Design Audit within MHSOP Services.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1. The University of Stirling Dementia Design Audit Tool aims to provide dementia specific care services with an understanding of what constitutes as a good and safe environment for people with dementia.

2.2 There are 11 criteria to be assessed within the University of Stirling Dementia Design Audit Tool (DSDC Version 2, 2010). The 11 criteria refer to specific areas within a unit e.g. entrance, bedrooms, lounges, external areas etc. There are 345 standards in total, of which 118 standards are identified as Essential and 227 identified as Recommended.

2.3 The audit took place between 1st April 2017 and 30 June 2017, within the following organic wards in each locality.

Table 1

Locality	Ward Audited in 2014
Durham and Darlington	Ceddesfeld
	Hamsterley
Teesside	Westerdale South
North Yorkshire	Rowan Lea
	Rowan Ward
	Springwood
	Ward 14
York & Selby	Acomb Garth
	Meadowfields

All detailed action plans can be seen in Appendix 1.

3. KEY ISSUES:

3.1 The ward level action plans identify steps to be taken to address the essential standards not currently met, however the majority of these require estate refurbishments.

3.2 Two wards have identified a small decline in specific assessment criteria since 2014:

3.3 In Teesside, Westerdale South reported a decline in the number of standards met for a number of the Stirling assessment units, specifically; the dining room, examination room and external areas. In total, there were 12 standards that were not achieved due to:

- The number of patients eating together exceeding the expected number of 10.
- The dining room was not considered domestic in appearance, due to the absence of any wall art.
- There were not enough seats for all residents in the dining room and not enough to accommodate staff interaction at mealtimes.
- The examination room provided no contrast between the floor and cupboards.
- Externally there were uneven surfaces, lack of colour contrast between internal and external surfaces and exterior furniture and the ground, way finding back into the building was unclear with little in the way of landmarks to assist residents to find the door and little opportunity for outdoor activities.

3.4 In North Yorkshire, Springwood ward reported a decline in the number of standards met for a number of the Stirling assessment units specifically; the lounge area and the hairdressing room. In total, there were 3 standards that were not achieved due to:

- The contrast between the skirting and floor in the lounge was not deemed to have sufficient contrast and toilet facilities were inadequately signposted from the lounge.
- The contrast between the skirting and floor in the hairdressing room was also deemed insufficient.

3.5 Requirement that we continue to increase the knowledge and application of the Stirling essential standards amongst clinical and non - clinical staff to ensure that consideration is given to these standards during any environmental change.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
The Stirling standards have been recognised in previous CQC reports as good practice in terms of safety and effectiveness.

4.2 **Financial/Value for Money:**
It has been recognised that a pragmatic approach is required in relation to Stirling standards which require major refurbishments. Clinicians and estates department staff continue to work together during periods of change in ward areas.

There will also be costs associated with training.

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

4.4 **Equality and Diversity:**
Nil

4.5 **Other implications:**
The current consultation regarding Ward 14 at the Friarage Hospital may impact on the ward based action plan.

Through the undertaking of this audit it has been identified that of the 4 staff who originally undertook training in the Stirling Essential Standards Audit in 2012, only 2 are now able to support this work due to their current roles and capacity. Ideally the trust would benefit from increasing the number of staff trained in these standards from both the clinical and estate staff groups.

5. RISKS:

Refurbishment and redecoration programmes are planned into the life cycle of all buildings whether this is part of the TEWV estate or a PFI project from which TEWV provides services.

For some areas, the refurbishment plan is scheduled for 2017/18, however some areas such as Bowes Lyon, Picktree and Westerdale South have refurbishment programmes several years hence, therefore any bespoke requirements that are needing to be done ahead of the agreed refurbishment schedule are likely to incur a considerable cost.

The timelines and potential cost implications for all outstanding essential standards which relate to planned estate work will be a significant factor in complying fully with all 118 standards.

6. CONCLUSIONS:

There has been steady progress in working towards the Stirling Essential Standards and achieving a compliance rate of 83%, however the agreed timescales for undertaking refurbishment and re-decoration within the identified estates will have an impact on achieving full compliance unless this can be undertaken ahead of schedule at a potentially significant cost.

Teams continue to explore alternative solutions to address the outstanding issues to ensure that the MHSOP can achieve compliance in all the essential Stirling standards.

7. RECOMMENDATIONS:

Board is asked to note that:

- Clinical teams will progress their revised action plans following this audit, ensuring that any areas identified which are not manageable within the clinical team are brought to the attention of the appropriate department.

- Monitoring progress through the MHSOP Clinical Audit subgroup with exception reporting to SDG and the relevant QuAG will continue.
- Additional training requirements for clinical and non-clinical staff will be supported.
- The MHSOP Audit programme 2018/19 will include a Trust-wide audit of both the essential and recommended Stirling standards.
- Continuous dialogue and collaborative working between clinical and estate teams to ensure that future changes to estates incorporates the standards as described by the Stirling standards will continue.

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Mental Health Services for Older People

Clinical Audit Action Plan

COMPLIANCE LEVEL: GREEN

TITLE OF CLINICAL AUDIT:	Clinical Audit of the University of Stirling Dementia Design Audit Tool	**PROJECT LEAD:**	Sharon Tufnell
AUDIT NUMBER:	5206MHSOP17	**AUDIT DATE:**	June 2017

Links to ward action plans – see following pages

Durham and Darlington	Teesside	North Yorkshire	York and Selby
Ceddesfeld Hamsterley	Westerdale South	Rowan Lea Rowan Ward Springwood Ward 14	Acomb Garth Meadowfields

Progress on actions will be monitored by the Clinical Audit and Effectiveness team.
Further audit work can be used to assess progress on reaching the essential standards.

List of action plans

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Ceddesfeld, Durham and Darlington							
1.	Unit 1 Entrance, corridors, wayfinding and lift – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture	3 beige chairs in corridor do not contrast with floor, to obtain quote for new chairs and submit cost to relevant committee	Lillian Woods, ward manager	30/09/2017		
2.		The flooring is consistent in colour/tone throughout including threshold strips	Thresh strips and change in colouring of floor in Quiet room, activity room and all bathrooms to be replaced so that floor is consistent in colour including thresh strips	Estates and ward manager Lilian Wood to ensure Stirling compliant when changed	Flooring will be changed under the Life cycle budget however no time scale as this is based upon the condition of the flooring		
3.	Unit 2 Lounge area – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture	Main lounge: small tables need colour overlay, conservatory lounge and music lounge: overlay in contrasting colour to floor needs to be attached to tables. Cost to be obtained to replace sofas and chairs and cost submitted to relevant committee	L.Woods - ward manager	30/09/2017		
4.	Unit 3 Dining room – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture (especially chairs)	Light pink chairs do not give sufficient contrast to floor; wooden tables do not contrast with wooden floor. Tables need contrasting colour overlay attached to top (one block colour no patterns). Cost to replace dining chairs to be obtained and submitted to relevant committee	L.Woods - ward manager	30/09/2017		
5.		The dining room is small. No more than 10 people with dementia eating together	Ward occupancy is up to 15 so does not meet standard - however usually less than 15 eating in room due to patient choice of eating at different times or in different area, alternative places for patients to eat are available	No capacity to reduce the number of patients eating in dining room	N/A Agreed within QUAG that standard is unable to be met but will be adhered to where possible		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Ceddesfeld, Durham and Darlington							
6.	Unit 4 Meaningful occupation		No action required 100% compliance				
7.	Unit 5 Examination room – essential standards not met		No action required 100% compliance				
8.	Unit 6 Hairdressing room – essential standards not met		No action required 100% compliance				
9.	Unit 7 Bedrooms – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture	Wooden dresser and beige chair do not give contrast with wooden flooring - chair needs to be changed to create contrast and dresser changed or overlay added to create contrast - to obtain cost to complete this work and submit to relevant committee	L.Woods - ward manager	30/09/2017		
10		The flooring is consistent in colour/tone throughout including threshold strips	Thresh strip leading between rooms into ensuite. Flooring needs to be consistent in colour including the colour of thresh strips	L.Woods - ward manager, Estates	Will be changed under the Life cycle budget however no time scale as this is based upon the condition of the flooring		
11	Unit 8 Ensuite provision		No action required 100% compliance				
12	Unit 9 Communal toilets/bathrooms	Tiling and wall colours contrast clearly with the grab rails	Grab rails need to be replaced to create contrast with white shower tiles. To ask estates to give an estimated cost for this work and submit to relevant committee for funding	L.Woods, ward manager	30/10/2017		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Ceddesfeld, Durham and Darlington							
13		Shower/bath controls are simple to operate. Tryout.	To change to easy to operate controls, current bath cannot be used independently so staff will always assist	Estates and ward manager Lilian Wood to ensure Stirling compliant when changed	Will be changed under the Life cycle budget however no time scale as this is based upon the condition		
14		Shower/bath controls have clear indications to help people understand which is hot and which is cold. Observe: Are the controls easy to understand with clear colour contrast?	To change to easy to operate controls, current bath cannot be used independently so staff will always assist	Estates and ward manager Lilian Wood to ensure Stirling compliant when changed	Will be changed under the Life cycle budget however no time scale as this is based upon the condition		
15	Unit 10 External areas	Colour contrast between the interior floor finish and exterior surfacing is minimal	Colour of flooring inside and out to be considered as part of life cycle works and when replaced will be replaced so that there is minimal contrast	Estates and ward manager Lilian Wood to ensure Stirling compliant when changed	Will be changed under the Life cycle budget however no time scale as this is based upon the condition of the flooring		
16		Service covers (manhole covers) where people are likely to walk are concealed	2 man hole covers would need to be concealed to blend in with flooring	Estates and ward manager Lilian Wood to ensure Stirling compliant when changed	Flooring will be changed under the Life cycle budget however no time scale as this is based upon the condition of the flooring		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Ceddesfeld, Durham and Darlington							
17	Unit 11 General Principles	The doors to the toilet areas should have a consistent signature colour throughout the building.	Ensuite toilets are not in signature blue colour. To obtain quote from estates on cost to place overlay toilet doors of ensuites and submit cost to relevant committee	Estates and ward manager Lilian Wood to ensure Stirling compliant when changed	30/10/2017		

List of action plans

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name - Hamsterley – Durham and Darlington							
1.	Unit 1 Entrance, corridors, wayfinding and lift – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture	Light chairs in corridor need to be replaced to give contrast with wooden floor. To obtain quote to replace chairs and submit cost to relevant committee	L.Crook - ward manager	30/09/2017		
2.		The flooring is consistent in colour/tone throughout including threshold strips	Change of colour from corridor leading into - kitchen, quiet room, activity room, toilets. Flooring needs to be changed to ensure consistent in colour throughout including threshold strips	Estates / L Crook ward manager	Will be changed under the Life cycle budget however no time scale as this is based upon the condition of the flooring		
3.	Unit 2 Lounge area – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture	Small tables need overlay in contrasting colour to floor attached (block colour no patterns)	L.Crook- ward manager	30/09/2017		
4.	Unit 3 Dining room – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture (especially chairs)	Tables need coloured overlay attached to create contrast with floor (block colour without patterns)	L.Crook - ward manager	30/09/2017		
5.		The dining room is small. No more than 10 people with dementia eating together	Ward occupancy is up to 15 so does not meet standard - however usually less than 15 eating in room due to patient choice of eating at different times or in different area, alternative places for patients to eat are available in different rooms	No capacity to reduce the number of patients eating in dining room	N/A Agreed within QUAG that standard is unable to be met but will be adhered to where possible		
6.	Unit 4 Meaningful occupation		No action required 100% compliance				

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name - Hamsterley – Durham and Darlington							
7.	Unit 5 Examination room – essential standards not met		No action required 100% compliance				
8.	Unit 6 Hairdressing room – essential standards not met		All standards NA				
9.	Unit 7 Bedrooms – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture	Wooden dresser and beige chair do not give contrast with wooden flooring - chair needs to be changed to create contrast and dresser changed or overlay added to create contrast. To cost up work and submit to relevant committee	L.Crook - ward manager	30/09/2017		
10	Unit 8 Ensuite provision		No action required 100% compliance				
11	Unit 9 Communal toilets/bathrooms	Tiling and wall colours contrast clearly with the grab rails	Grab rails need to be replaced to create contrast with white shower tiles. To ask estates to give an estimated cost for this work and submit to relevant committee for funding	L.Crook - ward manager	30/10/2017		
12		Shower/bath controls are simple to operate. Tryout	To change to easy to operate controls when unit needs to be replaced, current bath cannot be used independently so staff will always assist	Estates / ward manager	Will be changed under the Life cycle budget however no time scale as this is based upon the condition		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name - Hamsterley – Durham and Darlington							
13		Shower/bath controls have clear indications to help people understand which is hot and which is cold. Observe: Are the controls easy to understand with clear colour contrast?	To change to easy to operate controls when unit needs to be replaced, current bath cannot be used independently so staff will always assist	Estates / ward manager	Will be changed under the Life cycle budget however no time scale as this is based upon the condition		
14	Unit 10 External areas	The door contrasts clearly with the surrounding walls	Door into garden from wander pathway blends in with surrounding windows, contrasting film should be placed around door to create contrast. To obtain quotes from estates for this work and submit cost to relevant committee	L.Crook - ward manager	30/10/2017		
15		The door handle is clearly visible and contrasts against the door	To obtain quotes from estates for handle to be replaced to create contrast with door frame, cost to be submitted to relevant committee	L.Crook - ward manager	30/10/2017		
16		Service covers (manhole covers) where people are likely to walk are concealed	2 man hole covers would need to be concealed to blend in with flooring	Estates and L Crook ward manager	Flooring will be changed under the Life cycle budget however no time scale as this is based upon the condition of the flooring		
17	Unit 11 General Principles	The doors to the toilet areas should have a consistent signature colour throughout the building.	Ensuite toilets are not in signature blue colour. To obtain quote from estates on cost to place overlay toilet doors of ensuites and submit cost to relevant committee	L.Crook - ward manager	30/10/2017		

List of action plans

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name : Westerdale South, Teesside							
1.	Unit 1 Entrance, corridors, wayfinding and lift – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the walls	Floor does not contrast with white walls. Costing to be obtained to repaint walls in corridors and cost benefit analysis to take place to determine further action.	Ward manager, Stephen Parry	31/07/17		
2.		The flooring is consistent in colour/tone throughout including threshold strips	Three different floor types. Floors would have to be replaced forward to be compliant with Sterling guidance. Costing to be obtained to replace flooring in corridors and cost benefit analysis to take place to determine further action.	Ward manager, Stephen Parry	31/07/17		
3.		The flooring is consistent in colour/tone throughout including threshold strips	Threshold strips are black which do not match flooring. Threshold strips would have to be replaced with matching colours to the flooring of each room being entered to ensure compliance with Sterling guidance. Costing to be obtained to replace all threshold strips with ones that match the flooring and cost benefit analysis to take place to determine further action	Ward manager, Stephen Parry	31/07/17		
4.		There is clear signage to help wayfinding for everybody	Some incorrect signage. Lounge and dining room signs to be swapped around.	Ward manager, Stephen Parry	31/07/17		
5.		There is a relevant, easy to understand picture or graphic image as well as words on each sign	There are some out of use signs without pictures, also some new signage with pictures do not contrast with background colour i.e. the bed signs. Out of use signs to be removed and bed signs to be replaced.	Ward manager, Stephen Parry	31/07/17		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name : Westerdale South, Teesside							
6.		The bases of all signs offering wayfinding for residents are around 4 feet/1.2 metres from the ground. Measure	Some signs are too high. Out of use signs outside of all bedrooms to be removed.	Ward manager, Stephen Parry	31/07/17		
7.	Unit 2 Lounge area – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture	Main lounge is compliant. Female Lounge and Activity Room have furniture which does not contrast with the floor. Furniture to be relocated/replaced in these rooms.	Ward manager, Stephen Parry	31/07/17		
8.	Unit 3 Dining room – essential standards not met	The dining room is small. No more than 10 people with dementia eating together	Up to 14 people could be eating in this dining room due to size of ward. Other eating areas to be identified.	Ward manager, Stephen Parry	31/07/17		
9.		The dining room is domestic in appearance	Walls are bare. Artwork to be purchased and placed on the walls.	Ward manager, Stephen Parry	31/07/17		
10		There are enough seats for all residents	Extra seats to be purchased to ensure minimum 14 in dining area.	Ward manager, Stephen Parry	31/07/17		
11		There are extra/enough seats for staff interacting with residents at mealtimes	Extra seats to be purchased to ensure minimum 14 in dining area.	Ward manager, Stephen Parry	31/07/17		
12	Unit 4 Meaningful occupation		No action required 100% compliance				

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name : Westerdale South, Teesside							
13	Unit 5 Examination room – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture	No contrast between floor and cupboards. Costing to be obtained to replace floors and/or cupboards and cost benefit analysis to take place to determine further action.	Ward manager, Stephen Parry	31/07/17		
14	Unit 7 Bedrooms – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture	Beige furniture on beige floor. Furniture to be replaced.	Ward manager, Stephen Parry	31/07/17		
15		The entrance to the resident's bedroom is individualised. Observe: Doors - consider use of number or nameplate, doorbell, letter box, artwork, display boards/boxes, photographs. Observe: Individualisation is relevant for each resident	Not all rooms have individualised signage or pictures. All rooms to have an individual sign.	Ward manager, Stephen Parry	31/07/17		
16	Unit 8 Ensuite provision – essential standards not met	There are domestic-style toilet roll holders	IPC recommended toilet holders therefore will not be replaced.	Ward manager, Stephen Parry	31/07/17		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name : Westerdale South, Teesside							
17		Toilet roll holders contrast clearly with the background wall (or contain contrasting coloured toilet rolls).	Ward to identify if there are any darker toilet roll holders available and purchase if possible.	Ward manager, Stephen Parry	31/07/17		
18	Unit 9 Communal toilets/bathrooms – essential standards not met	Ceramic wall tiling or waterproof lining materials are domestic in appearance	Wall and floors in assisted bathroom are a similar colour. Wall is panelled so cannot be replaced. Action - Costing to be obtained to replace floors in bathrooms and cost benefit analysis to take place to determine further action.	Ward manager, Stephen Parry	31/07/17		
19		The room is homely	The room is homely. Due to assisted bath. No actions to be taken.	Ward manager, Stephen Parry	31/07/17		
20	Unit 10 External areas– essential standards not met	The door threshold to the outdoor area is level	Raised to prevent flooding. Would require building work to level. Costing to be obtained to replace base of door and cost benefit analysis to take place to determine further action.	Ward manager, Stephen Parry	31/07/17		
21		Colour contrast between the interior floor finish and exterior surfacing is minimal	Flooring would require replacing, costing and cost/benefit analysis to take place to determine further action.	Ward manager, Stephen Parry	31/07/17		
22		The way back into the building is clearly visible from the outdoor area. Observe: There is visible and clear signage indicating the way back into the building	Signage directing the way back into the building for courtyard to be purchased and installed.	Ward manager, Stephen Parry	31/07/17		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name : Westerdale South, Teesside							
23		There are landmarks to help identify the door e.g. specimen plant, sculpture etc.	Wall art to be purchased to be placed next to the doors in courtyard.	Ward manager, Stephen Parry	31/07/17		
24		Hard surfacing is level	Uneven throughout the garden. Building work and resurfacing of courtyard would be required. Costing to be obtained to resurface floors outside and cost benefit analysis to take place to determine further action.	Ward manager, Stephen Parry	31/07/17		
25		Hard surfacing is non-reflective. Observe: Sunlight does not create glare	White walls causing glare. Costing to be obtained to repaint walls outside and cost benefit analysis to take place to determine further action.	Ward manager, Stephen Parry	31/07/17		
26		Service covers (manhole covers) where people are likely to walk are concealed	Manhole covers to be purchased and installed.	Ward manager, Stephen Parry	31/07/17		
27		There are opportunities for activities. Observe: Raised planters; areas for tables and chairs; washing lines; greenhouses; sheds; putting green etc.	Raised planters to be purchased and installed.	Ward manager, Stephen Parry	31/07/17		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name : Westerdale South, Teesside							
28		There is sufficient colour contrast between the external furniture and the ground surface	Benches to be painted a darker shade.	Ward manager, Stephen Parry	31/07/17		
29	Unit 11 General Principles		No actions required 100% compliance				

List of action plans

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Rowan Lea, North Yorkshire							
1.	Unit 1 Entrance, corridors, wayfinding and lift – essential standards not met	The skirting contrasts with both the floor and walls	Some skirting and walls do not have contrast.	Estates	31/12/2017		
2.		The flooring is consistent in colour/tone throughout including threshold strips	Female lounge flooring not consistent in colour with corridor.	Estates	Flooring will be changed under the Life cycle budget however no time scale as this is based upon the condition of the flooring		
3.	Unit 2 Lounge area – essential standards not met	The skirting contrasts with both the floor and walls	No contrast between skirting and walls includes 2 walls in this area	Estates	31/12/2017		
4.	Unit 3 Dining room – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture (especially chairs)	No contrast between floor and furniture. Floor covering needs changing to include (see also action 6)	Estates	Flooring will be changed under the Life cycle budget however no time scale as this is based upon the condition of the flooring		
5.		The skirting contrasts with both the floor and walls	Insufficient colour contrast between walls and skirting	Estates	31/12/2017		
6.		The flooring is consistent in colour throughout including threshold strips	Floor covering contrasts with threshold strips.	Estates	Flooring will be changed under the Life cycle budget however no time scale as this is based upon the condition of the flooring		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Rowan Lea, North Yorkshire							
7.	Unit 4 Meaningful occupation		No actions required 100% compliance				
8.	Unit 5 Examination room – essential standards not met		No actions required 100% compliance				
9.	Unit 6 Hairdressing room – essential standards not met		No actions required all standards NA				
10.	Unit 7 Bedrooms – essential standards not met	The skirting contrasts with both the floor and walls	Skirting and walls have insufficient contrast	Estates	31/12/2017		
11.		The entrance to the resident's bedroom is individualised. Observe: Doors - consider use of number or nameplate, doorbell, letter box, artwork, display boards/boxes, photographs. Observe: Individualisation is relevant for each resident	Bed room doors need further individual work.	Shaun Burke, Ward manager with Occupational Therapist	30/09/2017		
12.		There are personal items in the resident's room	Resident's rooms need further individual work.	Shaun Burke, Ward manager with Occupational Therapist	30/09/2017		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Rowan Lea, North Yorkshire							
13.	Unit 8 Ensuite provision	Ceramic wall tiling or waterproof lining materials are domestic in appearance	Obtain and fix wall art	Shaun Burke, Ward manager with Activity coordinator	30/09/2017		
14.		The colour of the tiling/wall contrasts clearly with the colour of grab rails	Change white grab rail to blue as not enough contrast	Estates	31/12/2017		
15.		The room is homely	Obtain and fix wall art	Shaun Burke, Ward manager with Activity coordinator	30/09/2017		
16.		There are domestic-style toilet roll holders	Fit domestic type toilet roll holders. Request Hotel services to order the dispensers and request Estates to fix accordingly.	Shaun Burke, Ward manager with hotel services	30/09/17		
17.		Shower/bath controls are simple to operate	Add signage to explain Shower/bath controls	Shaun Burke, Ward manager with Activity Worker	30/09/2017		
18.		Shower/bath controls have clear indications to help people understand which is hot and which is cold	Fit shower/bath controls with clear indications of which is hot and which is cold using hot /cold blue red indicators	Estates – KL to review	31/12/17		
19.	Unit 9 Communal toilets/bathrooms	The colour of the toilet seat contrasts clearly with the colour and tone of the floor	Ward to work with Estates to replace blue toilet seat and grab rail so they contrast with blue floor.	Shaun Burke, Ward manager with estates	31/10/17		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Rowan Lea, North Yorkshire							
20.	Unit 10 External areas	Colour contrast between the interior floor finish and exterior surfacing is minimal	The significant contrast in colour could be mistaken as change in floor level. Estates to review actual colour contrast LRV's between surfaces and if deemed insufficient flooring will be changed under the Life cycle budget however no time scale as this is based upon the condition of the flooring	Estates	Flooring will be changed under the Life cycle budget however no time scale as this is based upon the condition of the flooring		
21.		The way back into the building is clearly visible from the outdoor area. Observe: There is visible and clear signage indicating the way back into the building	Fit way finding signs back into building	Shaun Burke, Ward manager with Activity Worker	30/09/2017		
22.		The door contrasts clearly with the surrounding walls	Door and window do not contrast with surrounding walls. Ward to investigate potential solutions e.g. using tape or planters and visual signage.	Ward	30/09/17		
23.		There are landmarks to help identify the door e.g. specimen plant, sculpture etc.	Fit way finding signs back into building as action 21.	Shaun Burke, Ward manager with Activity Worker	30/09/2017		
24.		The door handle is recognisable	The door handle colour blends with door colour – change door handle. Estates to review actual LRV of handle and door finish.	Estates	31/12/2017		
25.		The door handle is clearly visible and contrasts against the door	The door handle colour blends with door colour – change door handle. Estates to review actual LRV of handle and door finish	Estates	31/12/2017		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Rowan Lea, North Yorkshire							
26.	Unit 11 General Principles		No actions required 100% compliance				

List of action plans

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Rowan Ward, North Yorkshire							
1.	Unit 1 Entrance, corridors, wayfinding and lift – essential standards not met	The flooring is consistent in colour/tone throughout including threshold strips	Change the colour of the flooring/threshold strips so they are consistent in colour/tone – corridors. Ongoing issue	Estates	30/06/2018		
2.		Doors to safe outdoor areas are unlocked	Small rear garden unsafe to access due to needing cleaning / tidying - see external areas actions	Estates	31/10/2017		
3.		The flooring is consistent in colour/tone throughout including threshold strips	Change the colour of the flooring/threshold strips so they are consistent in colour/tone – entrance areas	Estates	30/06/2018		
4.	Unit 2 Lounge area – essential standards not met	The flooring is consistent in colour/tone throughout including threshold strips	Change the colour of the flooring/threshold strips so they are consistent in colour/tone - – lounge areas	Estates	30/06/2018		
5.	Unit 3 Dining room – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the walls	Change the colour of the walls/flooring so they contrast in colour - – dining room	Estates	30/06/2018		
6.	Unit 4 Meaningful occupation		No action required 100% compliance				
7.	Unit 5 Examination room – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the walls	Change the colour of the walls/flooring so they contrast in colour - examination room	Estates	30/06/2018		
8.	Unit 6 Hairdressing room – essential standards not met		No action required – All standards NA				

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Rowan Ward, North Yorkshire							
9.	Unit 7 Bedrooms – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the walls	Change the colour of the walls/flooring so they contrast in colour - bedrooms	Estates	30/06/2018		
10.		The flooring is consistent in colour/tone throughout including threshold strips	Change flooring/threshold strips so they are consistent in colour/tone - bedrooms	Estates	30/06/2018		
11.	Unit 8 Ensuite provision		No action required – All standards NA				
12.	Unit 9 Communal toilets/bathrooms	The flooring is consistent in colour throughout including threshold strips	Change flooring/threshold strips so they are consistent in colour/tone – communal bathrooms/toilets	Estates	30/06/2018		
13.		The room is homely	Obtain and fix wall art to give more homely feel	Jo Birks, ward manager with Occupational therapist	30/09/2017		
14.		The colour of the toilet seat contrasts clearly with the colour of the toilet bowl	Change toilet seats in rm number1050 and 1042 so they contrast with colour of the toilet bowl	Estates	30/09/2017		
15.		The colour of the toilet seat contrasts clearly with the colour and tone of the floor	Change toilet seats in rm number1050 and 1042 so they contrast with colour and tone of the floor	Estates	30/09/2017		
16.		Shower/bath controls are simple to operate. Tryout	Fit signage to assist with use of shower/bath controls	Jo Birks, ward manager with Occupational therapist	30/09/2017		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Rowan Ward, North Yorkshire							
17.		Shower/bath controls have clear indications to help people understand which is hot and which is cold. Observe: Are the controls easy to understand with clear colour contrast?	Fit signs to shower/bath controls to give clear indications of which is hot and which is hot/cold	Jo Birks, ward manager with Occupational therapist	30/09/2017		
18.	Unit 10 External areas	Colour contrast between the interior floor finish and exterior surfacing is minimal	Change red threshold strips to minimise colour contrast between the interior floor finish and exterior surfacing	Estates	30/06/2018		
19.		Hard surfacing is level	Repair uneven paving slabs	Estates	31/10/2017		
20.	Unit 11 General Principles		No action required 100% compliance				

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NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Springwood, North Yorkshire							
1.	Unit 1 Entrance, corridors, wayfinding and lift – essential standards not met	The skirting contrasts with both the floor and walls	The white skirting does not contrast enough with the floor to pass the audit. Change colour of white skirting so it contrast with floor colour. Estates to review as white skirting with an LRV of 99 should contrast with most floor finishes, however if deemed insufficient consider further action.	Estates	31/12/2017		
2.		The flooring is consistent in colour/tone throughout including threshold strips	Change flooring/threshold strips so they are consistent in colour/tone – entrance area etc.	Estates	Flooring will be changed under the Life cycle budget however no time scale as this is based upon the condition of the flooring		
3.		The bases of all signs offering wayfinding for residents are around 4 feet/1.2 metres from the ground. Measure	Reposition toilet signs so they are 4 feet/1.2 metres from the ground. Signs currently are positioned too high on the communal male and female toilet.	Estates	31/12/2017		
4.	Unit 2 Lounge area – essential standards not met	The skirting contrasts with both the floor and walls	The white skirting does not contrast enough with the floor to pass the audit. Change colour of white skirting so it contrast with floor colour. Estates to review as white skirting with an LRV of 99 should contrast with most floor finishes, however if deemed insufficient consider further action.	Estates	31/12/17		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Springwood, North Yorkshire							
5.		Toilet facilities are visible or are well signposted from the lounge	Fit signs from the lounge to assist wayfinding to the toilets.	Estates	31/12/2017		
6.	Unit 3 Dining room – essential standards not met	The skirting contrasts with both the floor and walls	The white skirting does not contrast enough with the floor to pass the audit. Change colour of white skirting so it contrast with floor colour – dining room Estates to review as white skirting with an LRV of 99 should contrast with most floor finishes, however if deemed insufficient consider further action.	Estates	31/12/17		
7.	Unit 4 Meaningful occupation		No action required 100% compliance				
8.	Unit 5 Examination room – essential standards not met	The skirting contrasts with both the floor and walls	The white skirting does not contrast enough with the floor to pass the audit. Change colour of white skirting so it contrast with floor colour – examination room. Estates to review as white skirting with an LRV of 99 should contrast with most floor finishes, however if deemed insufficient consider further action.	Estates	31/12/17		
9.	Unit 6 Hairdressing room – essential standards not met	The skirting contrasts with both the floor and walls	The white skirting does not contrast enough with the floor to pass the audit. Change colour of white skirting so it contrast with floor colour – hair dressing room. Estates to review as white skirting with an LRV of 99 should contrast with most floor finishes, however if deemed insufficient consider further action.	Estates	31/12/17		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Springwood, North Yorkshire							
10.		The flooring is consistent in colour throughout including threshold strips	Change flooring/threshold strips so they are consistent in colour/tone – hairdressing room. Flooring is a different colour from that within the corridor.	Estates	Flooring will be changed under the Life cycle budget however no time scale as this is based upon the condition of the flooring		
11.	Unit 7 Bedrooms – essential standards not met	The skirting contrasts with both the floor and walls	The white skirting does not contrast enough with the floor to pass the audit. Change colour of white skirting so it contrast with floor colour – bedrooms. Estates to review as white skirting with an LRV of 99 should contrast with most floor finishes, h however if deemed insufficient consider further action.	Estates	31/12/17		
12.	Unit 8 Ensuite provision	The flooring is consistent in colour/tone throughout including threshold strips	The threshold strip is grey on a beige/brown floor. Change flooring/threshold strips so they are consistent in colour/tone – ensuite provision	Estates	Flooring will be changed under the Life cycle budget however no time scale as this is based upon the condition of the flooring		
13.		Ceramic wall tiling or waterproof lining materials are domestic in appearance	Consider use off wall art to try and improve the domestic appearance of the environment. – ensuite provision	Tracey Hutchinson , ward manager with Occupational therapist	30/09/2017		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Springwood, North Yorkshire							
14.		The colour of the tiling/wall contrasts clearly with the colour of grab rails	There are NO grab rails in situ to assist with toilet or bathing transfers. This needs addressing with the fitting of blue wall mounted/drop down grab rails for all toilets and wall mounted fixed rails at the showers.	Estates	31/12/17		
15.		Shower/bath controls are simple to operate	Temperature controls and the flow controls are not clear for clients and there needs to be additional signage to clarify the use of shower/ bath controls	Tracey Hutchinson , ward manager with Occupational therapist	30/09/2017		
16.		Shower/bath controls have clear indications to help people understand which is hot and which is cold	Temperature controls and the flow controls are not clear for clients and there needs to be additional signage to clarify the use of these.	Tracey Hutchinson , ward manager with Occupational therapist	30/09/2017		
17.	Unit 9 Communal toilets/bathrooms	The room is made recognisable through the visibility of bathroom fittings and other items such as shampoo and towels	Focusing on the large bathroom: wall art needs to be considered to make this more of a recognisable environment as due to infection control products cannot be left within the bathroom.	Tracey Hutchinson , ward manager with Occupational therapist	30/09/2017		
18.		The colour of the toilet seat contrasts clearly with the colour and tone of the floor	Ward to work with Estates to replace blue toilet seat and grab rail so they contrast with blue floor.	Ward with estates	31/10/17		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Springwood, North Yorkshire							
19.	Unit 10 External areas	Colour contrast between the interior floor finish and exterior surfacing is minimal	Transition from brown lino flooring to outside non slip surface. Consider changing colours to minimise colour contrast between the interior floor finish and exterior surfacing	Estates	Flooring will be changed under the Life cycle budget however no time scale as this is based upon the condition of the flooring		
20.		The way back into the building is clearly visible from the outdoor area. Observe: There is visible and clear signage indicating the way back into the building	There needs to be an additional sign placed on the left hand door which is a picture sign to the lounge for those with word recognition issues. Ward staff to order sign and request installation by estates.	Ward with Estates -	31/12/2017		
21.		There is sufficient colour contrast between the furniture and the ground surface	Outside furniture needs painting to improve contrast.	Estates	31/12/2017		
22.		Plants are not harmful. Observe: No poisonous or spiny plants within reach of users	Review planting. There is Pampas grass in the garden space which could cause cuts. In addition there is some large pointed planting located close to the entrance doors to the unit.	Estates	31/12/2017 –		
23.	Unit 11 General Principles		No action required 100% compliance				

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NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Ward 14, North Yorkshire							
1	Unit 1 Entrance, corridors, wayfinding and lift – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture	There are small tables in the corridor which blend in with the flooring. They need to be either made contrasting or replaced	Sharon Airey, ward manager	30/06/17		Action completed as discussed with Gillian Woodrup 3/7/17
2		The flooring is consistent in colour/tone throughout including threshold strips	The flooring is consistent but it is wood panelling effect with variations in tone. It will need to be replaced with a consistent colour flooring	Estates	Consideration as capital refurbishment - flooring replaced totally within last 4 years		
3		Doors open against the wall to allow a full view of rooms	This varied in the unit some doors could not open against the wall to allow a full view of rooms.	NA	30/06/17		Action completed as discussed with Gillian Woodrup 3/7/17. No further action to be taken. This cannot be improved upon in the current environment
4		The flooring is consistent in colour/tone throughout including threshold strips	The flooring is consistent but it is wood panelling effect with variations in tone. It will need to be replaced with a consistent colour flooring	Estates	Consideration as capital refurbishment - flooring replaced totally within last 4 years		
5		The bases of all signs offering wayfinding for residents are around 4 feet/1.2 metres from the ground. Measure	Some signs are too high and need to be lowered. Review to be carried out on signage by end of July 2017	Sharon Airey, ward manager	30/07/2017		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Ward 14, North Yorkshire							
6	Unit 2 Lounge area – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture	All lounges have the same wood panelling effect flooring. There is strong contrast with the seating but the legs are wood which blend in. Floor surface requires replacing	Estates	30/06/17		Action complete das discussed with Gillian Woodrup 3/7/17
7		The flooring is consistent in colour/tone throughout including threshold strips	Wood panelling effect flooring which varies in tone. Floor needs replacing - consistent colour/tone	Estates	Consideration as capital refurbishment - flooring replaced totally within last 4 years		
8	Unit 3 Dining room – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture (especially chairs)	Wood panelling effect flooring which varies in tone. Floor needs replacing - consistent colour/tone	Estates	Consideration as capital refurbishment - flooring replaced totally within last 4 years		
9		The colour of the carpet/floor covering contrasts with the colour of the walls	The lighting in this room makes the room feel overly beige- a lighter wall would add more contrast. Action required is to paint walls in a lighter colour. Lighting review to be carried out by TEWV estates and South Tees estates - by end of June 2017	Estates	30/06/17		
1		The flooring is consistent in colour throughout including threshold strips	Wood panelling effect flooring which varies in tone. Floor needs replacing - consistent colour/tone	Estates	Consideration as capital refurbishment - flooring replaced totally within last 4 years		
1	Unit 4 Meaningful occupation		No action required 100% compliance				

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Ward 14, North Yorkshire							
1	Unit 5 Examination room – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the walls	The lighting in this room makes the room feel overly beige- a lighter wall would add more contrast. Action required is to paint walls in a lighter colour. Lighting review to be carried out by TEWV estates and South Tees estates - by end of June 2017	Estates	30/06/2017		
1	Unit 6 Hairdressing room – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the walls	Wood panelling effect flooring which varies in tone. Floor needs replacing - consistent colour/tone	Estates	Consideration as capital refurbishment - flooring replaced totally within last 4 years		
1	Unit 7 Bedrooms – essential standards not met	The colour of the carpet/floor covering contrasts with the colour of the furniture	Wood effect flooring with wood beds and wood effect furniture. Floor requires replacing for contrast	Estates	Consideration as capital refurbishment - flooring replaced totally within last 4 years		
1		The flooring is consistent in colour/tone throughout including threshold strips	Wood panelling effect flooring which varies in tone. Floor needs replacing - consistent colour/tone	Estates	Consideration as capital refurbishment - flooring replaced totally within last 4 years		
1		There are personal items in the resident's room	Variation noted in amount of personal items. Ward staff to personalise any bare rooms	Sharon Airey, ward manager	30/09/2017		
1		There is clear signage to aid wayfinding to the nearest toilet	Additional toilet signage needed for corridors to improve wayfinding	Sharon Airey, ward manager	30/09/2017		
1	Unit 8 Ensuite provision		No action required – All standards NA	NA	NA		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Ward 14, North Yorkshire							
1	Unit 9 Communal toilets/bathrooms	The flooring is consistent in colour throughout including threshold strips	Not in all bathrooms some have a distinct colour change. Needs replacing in 1 bathroom. Review to be carried out by estates and ward manager by end of June 2017	Sharon Airey, ward manager / Estates	30/06/2017		
2		Wall colours are warm and light to maximise light levels	Colours are not warm and light. Grey panels in place. Walls need to be a warmer colour. Review to be carried out by estates and ward manager by end of June 2017	Sharon Airey, ward manager / Estates	30/06/2017		
2		The room is homely	Room feels clinical Ward staff to purchase wall art	Sharon Airey, ward manager	31/07/2017		
2		The colour of the toilet seat contrasts clearly with the colour of the toilet bowl	White toilet seats. Replace with contrasting colour seats. Estates to source seats and arrange for replacements - end of June	Estates	30/06/2017		
2	Unit 10 External areas	The door threshold to the outdoor area is level	Raised threshold which is a trip hazard. Requires improved threshold. Review to be carried out by estates and ward manager by end of June 2017	Sharon Airey, ward manager /Estates	30/06/2017		
2		Colour contrast between the interior floor finish and exterior surfacing is minimal	Colour contrast from wood effect flooring to grey paving slabs Requires change of flooring. Flooring replaced totally within last 4 years	Estates	Consider as part of any future capital refurbishment - flooring replaced totally within last 4 years		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Ward 14, North Yorkshire							
2		The way back into the building is clearly visible from the outdoor area. Observe: There is visible and clear signage indicating the way back into the building	Requires additional signage at large and small court yard and 1 set of doors in the small court yard needs to be blended to avoid confusion. Review to be carried out on signage by end of July 2017.	Sharon Airey, ward manager/ Estates	31/07/2017		
2		There are landmarks to help identify the door e.g. specimen plant, sculpture etc.	Signature landmark plant or wall art required to help identify door	Sharon Airey, ward manager	31/07/2017		
2		Where adjacent surfaces vary in level, e.g. from a single step height to much greater heights, a balustrade of suitable height is provided. Observe: Balustrade 1.1 metres high and where there is a significant drop, is higher and slopes inward or has a sloping top	There are handrails in place in courtyards but there is a single step with no handrail in the small courtyard. This has been disguised by a plant currently. Estates to review and action if required. Review to be carried out by estates and ward manager by end of June 2017	Sharon Airey, ward manager/ Estates	30/06/2017		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Ward 14, North Yorkshire							
2		Hard surfacing is level	Courtyards have a mix of floor coverings- paving slabs, tarmac, block paving, chippings, small courtyard requires cleaning , Major refurb required in large courtyard to meet standards. Review to be carried out by estates and ward manager by end of June 2017	Sharon Airey, ward manager/ Estates	30/06/2017		
2		Hard surfacing is non-slip	Mixed surfaces- see above action 28 Review to be carried out by estates and ward manager by end of June 2017	Sharon Airey, ward manager/ Estates	30/06/2017		
3		There is sufficient colour contrast between the furniture and the ground surface	White furniture yes but wood furniture needs more contrast- paint or stain Minor works required by services to request works	Estates	31/07/2017		
3		Plants are not harmful. Observe: No poisonous or spiny plants within reach of users	Some roses in small courtyard which are spiny- need to be removed and replaced	Sharon Airey, ward manager with Ward staff	31/07/2017		
3	Unit 11 General Principles	The doors to the toilet areas should have a consistent signature colour throughout the building.	Signature colour required throughout Review to be carried out on signage by end of July 2017	Sharon Airey, ward manager/ Estates	31/07/2017		

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NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Acomb Garth, York and Selby							
1.	Unit 1 Entrance, corridors, wayfinding and lift – essential standards not met	The flooring is consistent in colour/tone throughout including threshold strips	Flooring in the corridor area is in 3 main blocks of colour - all brown but of different shades. Light, Medium and Dark brown. This will be taken in to consideration for planning the 2019 new hospital for York and Selby. Deadline of 31/10/2017 set to check progress with development of specification for new hospital.	Gary Matfin, Ward Manager with Head of Service	31/10/2017		
2.		Doors to safe outdoor areas are unlocked	Central courtyard is locked due to risk of falls as surfaces are uneven. A risk assessment is in place - access is under supervision only. Estates to replace to replace loose gravel with flag stones and repair external lighting. This work is scheduled to be completed by 7/7/2017	Estates	31/08/2017		
3.	Unit 2 Lounge area – essential standards not met	Toilet facilities are visible or are well signposted from the lounge	Signage visible from lounge near dining room but not the quiet lounge. Additional signage to be put in place. Signage is on order, estates to fit.	Gary Matfin, Ward Manager, with estates	31/07/17		
4.	Unit 3 Dining room – essential standards not met	The dining room is small. No more than 10 people with dementia eating together	Large room but has reduced seating to accommodate 8 patients out of 14. Seating in the dining room is reduced. There are alternative areas on the ward for patients to eat when clinically indicated that a dining room would not be the best environment.	NA N			**Complete**

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Acomb Garth, York and Selby							
5.		The dining room is domestic in appearance	Further work is needed to make the room more domestic / sociable i.e. arm chairs and coffee tables. Also a unit to house the record player and storage for the CDs and Records. Speakers need to be wall mounted. This is in accordance with a CQC recommendation to avoid a blanket ban on locking the room when not in use and making it a more comfortable area for patients and visitors to relax outside mealtimes.	Gary Matfin, Ward Manager to discuss with Head of Service	31/08/2017		
6.	Unit 4 Meaningful occupation	There is easy access to safe outside space with facilities for residents to engage in light gardening or exploring, where desired. Observe: The exit is unlocked; the exit is not blocked by furniture	Complete garden development. See action 2. Door is currently locked as the garden is still under development. Access is under supervision only. Developing participation in gardening is an ongoing project that will progress further on completion of the courtyard refurbishment.	Estates and Gary Matfin, Ward Manager with occupational therapist	30/08/2017		
7.	Unit 5 Examination room – essential standards not met		No action required 100% compliance				
8.	Unit 7 Bedrooms – essential standards not met	The room can be made dark overnight but there is an optional facility for very low level lighting	Curtains and net curtains are in place. There are dimmer switches in situ but these don't work. Estates to undertake an audit of the light quality as basis for agreeing any further work.	Gary Matfin, Ward Manager, to raise with Estates	31/08/2017		

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Acomb Garth, York and Selby							
9.		There is clear signage to aid wayfinding to the nearest toilet	Appropriate signage in place but more is required to direct patients to toilets. Additional signage to be put in place. Signage is on order, estates to fit.	Gary Matfin, Ward Manager, with estates	31/07/2017		
10.	Unit 8 Ensuite provision	There is a sign on the door to aid wayfinding	Appropriate signage in place but more is required to direct patients to toilets. Additional signage to be put in place. Signage is on order, estates to fit.	Gary Matfin, Ward Manager, with estates	31/07/2017		
11.	Unit 9 Communal toilets/bathrooms		No action required 100% compliance				
12.	Unit 10 External areas	Access to outdoor areas is available during the day. Observe: The doors to the outdoor areas are unlocked	See also action points 2 and 6	Estates	31/08/2017		
13.	Unit 11 General Principles		No action required 100% compliance				

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NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Meadowfields, York and Selby							
1	Unit 1 Entrance, corridors, wayfinding and lift – essential standards not met		No action required 100% compliance				
2	Unit 2 Lounge area – essential standards not met		No action required 100% compliance				
3	Unit 3 Dining room – essential standards not met	The dining room is small. No more than 10 people with dementia eating together	Large room but has reduced seating to accommodate 12 patients out of 14. No further action suggested	NA	NA		
4	Unit 4 Meaningful occupation		No action required 100% compliance				
5	Unit 5 Examination room – essential standards not met		No action required 100% compliance				
6	Unit 6 Hairdressing room – essential standards not met		No action required 100% compliance				
7	Unit 7 Bedrooms – essential standards not met	There is clear signage to aid wayfinding to the nearest toilet	Appropriate signage in place but more is required to direct patients to toilets (in bedroom areas and from Physio, etc.)	Estates	31/07/2017		
8	Unit 8 Ensuite provision	There is a sign on the door to aid wayfinding	Appropriate signage in place but more is required to direct patients to toilets	Estates	31/07/2017		
9	Unit 9 Communal toilets/bathrooms		No action required 100% compliance				
1	Unit 10 External areas		No action required 100% compliance				

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
Ward name – Meadowfields, York and Selby							
1	Unit 11 General Principles		No action required 100% compliance				

ACTION PLAN OWNER:	Heads of Service, Modern Matrons and ward managers	**DATE**:	12/07/2017
PLAN AGREED BY:	MHSOP Audit Sub Group	**DATE**:	12/07/2017

ITEM NO. 7

FOR GENERAL RELEASE

Board of Directors

DATE:	**20 July 2017**
TITLE:	**CYPS Management of Waiting Times Update**
REPORT OF:	**Brent Kilmurray**
REPORT FOR:	**Information**

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

Executive Summary:

The Board has received previous reports regarding the work under way to address concerns about excessive waits within CAMHS services. This report includes an update from each locality and provides the position reported up to June 2017 together with a narrative regarding the key areas of action that have been completed and/or are under way.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**20 July 2017**
TITLE:	**CYPS Management of Waiting Times Update**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Board has received previous reports regarding the work under way to address concerns about excessive waits within CAMHS services. This report includes details from each locality and provides the position reported to june 2017 and a narrative regarding the key areas of action that have been completed and/or are under way.

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

3. KEY ISSUES:

3.1 Durham & Darlington

3.1.1 The service has shown sustained improvement in relation to access, showing an incremental increase in the percentage of patients seen within the 4 week target, the current position being 95%.

3.1.2 A review of cases where waiting times to access the service have exceeded 4 weeks has demonstrated issues regarding patients responding to telephone contact and delays in responding to letters and/or choice of appointment.

3.1.3 All cases are discussed as part of daily lean management, enabling the teams to undertake a more transparent review of the teams performance as well as minimising any potential breaches.

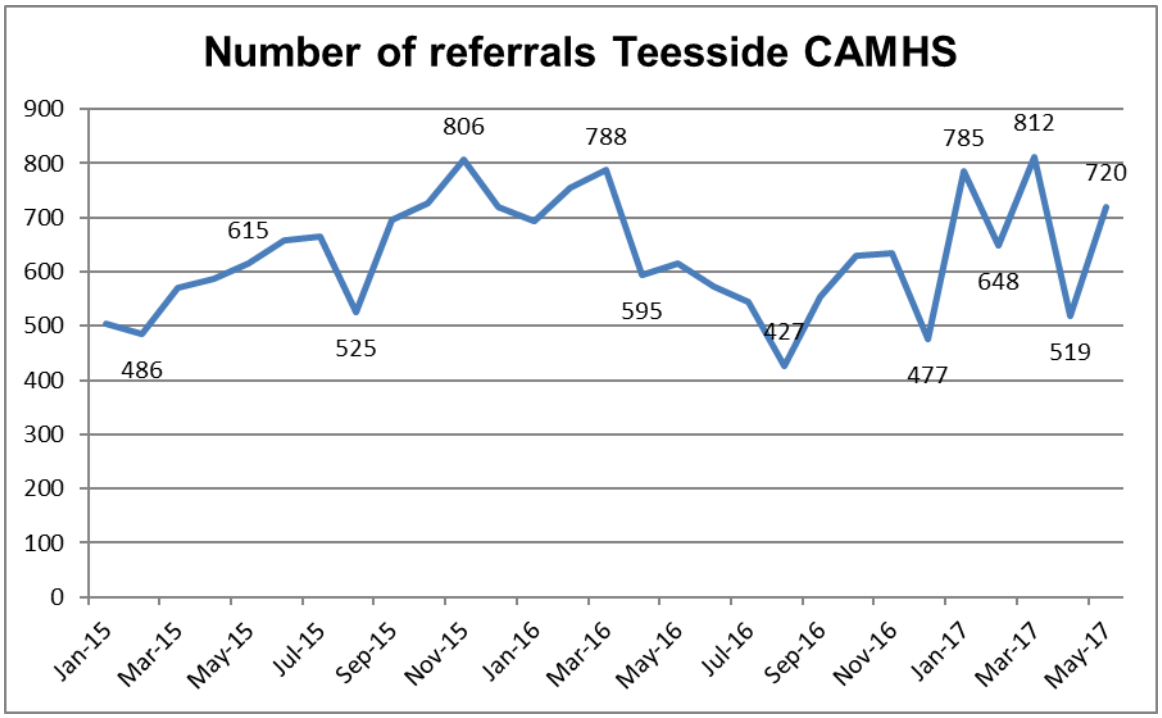
3.1.4 It has also been highlighted that the service provided has a small core team supported by two staff who are currently rotered in from community CAMHS. It is therefore suggested that this should become a more permament arrangement creating a dedicated core team through transfer of existing resources into the single point of access (SPA).

3.2 Teesside

3.2.1 The service has continued to maintain an improved position against waiting times, the current position showing 97.9% of patents not exceeding the 4 week target from referral to initial appointment. Whilst this improved position is being maintained , pressures are beginning to be seen in the wait for a 2nd follow up appointment. Recent data demonstrates that the service is struggling to achieve the 9 week target for a 2nd follow up appointment.

3.2.2 As team managers continue to play a pivotal role implementing and embedding the key actions and processes that have resulted in such a strong performance position, the service demand upon the CAMHS team continues to increase. The graph below shows the referral rate from 2015 to May 2017.

Tees External Referrals



3.2.4 Externally partners continue to face financial cuts with the Local Authorties being significantly affected. Whilst other services withdraw, the demand for children services still remains and where once a multi-agency approach would have been in place, it is now the expectation that CAMHS will fill the gap.

3.2.5 TEWV have recently requested that commissioners acknowledge the current situation.

3.3 North Yorkshire

3.3.1 Through the PPCS programme a considerable amount of work has been undertaken to review the systems and processes within the three locality teams, the most significant change has been an introduction and incorporation of a visual control board into the service QUAG which will ensure information about the service, including waiting time position can be reviewed and acted upon in a timely way. PPCS2 (Pathways) is also being piloted in one of the teams (Northallerton) and already learning is being shared with the other two teams.

3.3.2 Staffing levels in Scarborough is demonstrating a slightly improved position with only one vacancy now needing to be recruited to, however long term sickness continues to have an impact, while Harrogate is showing a rather worse position with the the loss of four B6 posts in a short period of time reducing the team from 10.45wte to 6.75wte. It is anticipated that this will have an impact on waiting times for initial face to face assessments. In order to minimise the impact, action was taken to commence recruitment before formal resignations were received.

3.3.3 The Single point of access (SPOA) telephone assessments has had a positive impact upon waiting times with the service demonstrating an improved position of approximately 95% of patients being seen within 4 weeks of referral.

3.3.4 Following an RPIW a new intiative was introduced inviting patients and or parents to a Wellbeing Workshop which promotes mental health first aid as a first line intervention. Whilst this is of benefit to service users this unfortunately masks increasing demands; referrals are becoming more complex and some professionals eg GPs are using the service as a screening service expecting the SPOA to direct referrals to the correct service. At peak times SPOA struggles to meet demand hence additional resource has had to be found (clinical and admin) to cope with the demand. A review of SPOA is underway in order to identify ways to improve efficiency. The internal target of contacting patients within 24hours is still being delivered in the majority of cases.

3.3.5 The service is now currently planning for wave 7 of CYP-IAPT. Discussions have takien place with commissioners in the hope that some financial support could be given however discussions have been unsuccessful. Provision has been made within the service for 5 members of staff to attend clinical training, 4 to complete leadership training, as well as 6 PWPs, it is anticipated that the service will be able to financially support this cohort of trainees.

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3.3.6 Whilst the service has made some significant improvements to reduce the waiting times the interface between each part of the service is becoming more complex and therefore requires more attention and time to re-

negotiate pathways for patients, ensuring that a patient's wait from referral to treatment is maintained at 4weeks or below.

3.4 Vale of York

3.4.1 Performance against the 4 week target is an improving picture. The current position shows that 81% of patients were seen within 4 weeks of referral. This has in part been due to the acceptance of the initial Telephone Consultation as the first appointment from April 2017**.**

3.4.2 The service undertook a 'Stop the Line' process in May, with a follow-up meeting in June to address the throughput issues in the SPA. More capacity was committed to carrying out the telephone assessments, alongside which more Initial Comprehensive Assessment (ICAs) slots were also offered in June and July. This was achieved by staff working additional hours into SPA and carrying out extra ICAs. Whilst this has impacted on the timescales at the front end of the service, it has inevitably impacted on the intervention arm of the service. However, once the backlog of referrals in SPA has been addressed, the future modelling of SPA staffing and the allocation of ICA slots should meet the anticipated demand.

3.4.3 As part of the service redesign all Tier 3 CAMHS staff now have clear job plans based on the Trust's CAMHS clinical pathways. Extra ICAs (as described above) were allocated by the PMHW team to clinicians working on the pathways that seem most relevant to the young person's clinical needs, as ascertained by the telephone consultation. This will lead to families experiencing fewer 'hand offs' between assessment and treatment appointments and should also improve the diagnostic conversion rates such as for Autistic Spectrum Condition (ASC), which is of significant interest to the Vale of York CCGs.

3.4.4 The service undertook 2 waiting list iniatives, one funded internally by the Trust to address the ASC Waiting List and one funded by NHSE to address the Attention Deficit Hyperactivity Disorder and Low Mood and Anxiety Waiting Lists. The services of locum therapists and a private provider were utilised to help manage the waiting lists. Whilst this benefitted families who have been waiting for a significant number of months, it has only provided temporary relief given the temporary nature of the funding.

3.4.5 Staff sickness in the service has improved since the last report, from 4% to 1.7%. The 2 members of staff who were reportring work related stress have both returned to work but continue to flag the size of the team's caseloads as a major contributor to their stress levels. The challenge therefore is in managing large caseloads, balancing adherence to the intervention model laid out in the clinical pathways and continuing to reduce waiting times.

3.4.6 A comprehensive capacity and demand exercise has taken place the findings of which have been used to produce trajectories of staffing levels required to address the intervention waiting lists and staffing levels required once the back log has been reduced. This information has been shared with the Vale of York CCG and will be subject to further discussion internally.

3.5 Austistic Spectrum Disorder (ASD)

3.5.1 Across the Trust CAMHs services continue to demonstrate a deteriorating position, the lowest wait reported from referral to assessment as of the 1 July 2017 is 42 weeks, the longest reported wait is 108 weeks.

3.5.2 The issues regarding waiting times and the increasing demands upon the services have been raised with the relevant commissioners. Whilst the teams wait for further feedback from commissioners, Hartlepool and Stockton on Tees CCG undertook a re-design event in May 2017, the result of which has led to a project lead being appointed in July 2017 with a remit to explore a needs led approach. The teams continue to raise these issues with commissioners.

4. IMPLICATIONS:

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

4.2 Financial/Value for Money:
There are no direct financial implications of this paper

4.3 Legal and Constitutional (including the NHS Constitution):
There are no legal or constitutional implications of this paper.

4.4 Equality and Diversity:
There are no equality or diversity implications of this paper.

4.5 Other implications:
There are no other implications of this paper.

5. RISKS:

These matters are covered within the locality risk registers.

6. CONCLUSIONS:

Through strong leadership and the implementation and introduction of new ways of working supported through the PPCS programme the services have demonstrated an improving position month on month from their baseline position in 2016; Durham & Darlington, North Yorkshire and Teesside are all reporting over 95% compliance with the 4 week target and the Vale of York reporting 81% achievement.

The challenges moving forward will be to continue to improve and sustain these optimum waiting times from referral to 1st treatment and to ensure that the provision of follow up care (2nd appointment) can be also be managed within the agreed waiting times. This will become ever more apparent when set against increasing demand, resource issues and a locally and nationally changing picture for CAMHS services.

7. RECOMMENDATION:

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

Brent Kilmurray
Chief Operating Officer & Deputy Chief Executive
July 2017

ITEM NO. 8

BOARD OF DIRECTORS

FOR GENERAL RELEASE

DATE:	**20th July 2017**
TITLE:	**The TEWV Way (including the TEWV Values and Behaviours consultation exercise)**
REPORT OF:	**Chief Operating Officer and Director of Human Resources and Organisational Development**
REPORT FOR:	**Consultation and Decision**

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

Executive Summary:

A workshop was organised and took place on 5th May 2017 to discuss 'The TEWV Way'

This paper sets out the background, workshop discussion and proposals for future related activities.

Recommendations:

i) To note the contents of the paper and to comment accordingly.

ii) To endorse the proposals described within section 4 of the report.

iii) To receive an update report in January 2018

MEETING OF:	**Board of Directors**
DATE:	**20th July 2017**
TITLE:	**The TEWV Way (including the TEWV Values and behaviours consultation exercise)**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this paper is to propose the next steps and future direction of the 'TEWV Way' Business Plan priority, including a consultation exercise about the TEWV values and behaviours statements and the staff compact.

1.2 The current values and behaviours have been in place since 2010 and one of the 2017/18 Board business plan priorities is to review and refresh the values and behaviours work (ref Directors Action Log of 29/11/2016 minute 16/289).

1.3 This paper sets out some of the background and issues relating to this work, proposals for a consultation exercise with staff, service users and carers and provides feedback from a TEWV Way planning event that took place on 5th May 2017.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 TEWV developed its current values and behaviours statements during 2009/10. These statements have been used ever since to articulate the way in which we seek to do things within TEWV.

2.2 Staff, service users and carers took part in consultation workshops during 2009 and early 2010. The staff compact was consulted upon and developed separately in 2008. The outcomes of these activities were:

Trust Values:

- Commitment to Quality
- Respect
- Involvement
- Wellbeing
- Teamwork


Trust Values and Behaviours.pdf


0993 TEWV Staff Compact Amended ve


Values Poster with text.pdf

2.3 The Board of Directors has agreed that a values and behaviours statements consultation exercise be undertaken with staff, service users and carers as part of the TEWV Way Business Plan priority to improve how we work with internal and external stakeholders.

2.4 Since the original values and behaviours consultation exercise in 2009/10 was carried out there have been identified a number of pre-existing and subsequent developments that resonate strongly and link with the TEWV Way. These include:

- **The Trust Quality Improvement System (QIS)** - a process designed to help maximise quality and eliminate waste and improve the quality and value of the services we provide to our patients and carers as being at the core of what we do.

- **The Recovery Strategy** – based around the theory of personal recovery and the process of building a meaningful and satisfying life, with or without ongoing difficulties/symptoms. Personal recovery is felt to be much more relevant when considering mental health and distress, as often it is not the diagnosed symptoms which are most troubling but the desire for a greater sense of purpose, an understanding of their distress or more control over what happens to them.

- **Leadership and Management Development Strategy** – ongoing work to engage all leaders and managers in TEWV to develop a coaching culture as part of everyday work and conversations and in doing this ensure services are recovery focused and optimise patient outcomes and experience. This approach has been developed recently as part of the Purposeful and Productive Services programme of work.

2.5 In order to progress the TEWV Way Business Plan activity a half day event was arranged and took place on 5th May 2017. Attendees included Brent Kilmurray, Chief Operating Officer; David Levy, Director of Human Resources; psychologists; senior nursing staff; representatives from the Recovery Project; Communications; Head of Service for KPO; Planning; HR Organisational Development and operational support staff. Also attending was Rhiannon Barker from the Point of Care Foundation (with links into the Work and Health Foundations that are supporting national research about staff engagement).

3. Key Issues

3.1 The event was designed as a workshop which included three group discussions and was prefaced by a brief discussion over whether this theme should continue to be called the 'TEWV-Way'.
The consensus of opinion was that in response to negative feedback received by event participants the name of the priority ought to be changed from the TEWV Way to another name.

The group discussions were:

- Do we have a common understanding of what the current TEWV way is?

- What is the desired future state for the TEWV Way?
- Gap analysis - what do we need to do to achieve the desired future state?

3.2 Key themes:

3.2.1 Discussion 1: What do we believe the current TEWV Way is: Though there were not any consistent clear definitions of what this was felt to be recurring themes were that:

- Good leadership
- We can deliver / are efficient /a 'can do' attitude
- Engaged staff
- Positive
- Strong culture of respect with colleagues, patients and carers.
- Good / caring / friendly staff who want to do 'the best job'. Welcoming.
- Strong improvement activities which deliver
- Disconnect between some senior and junior staff within TEWV
- Areas of silo working
- Pockets of negative culture

3.2.2 Discussion 2: Desired Future State for TEWV Way:

- An increased use of co-production with colleagues, patients and carers across a broad range of activities
- A refresh of patient centeredness / recovery
- More listening and validating
- A place where people thrive
- We should aim to exceed expectations
- Flexible / creative workforce
- Competent / confident workforce
- A learning organisation
- An organisation with a just culture

3.2.3 Discussion 3: What do we need to do to achieve the desired future state?

- Undertake a refresh of values / behaviours / compact awareness in an explicitly co-produced way
- Set annual priorities for development rather than trying to do everything at once.
- Build upon what has been done – there was a strong feeling that this refresh shouldn't 'throw the baby out with the bathwater' as good work has been undertaken.
- Need to articulate what has already been done and map out / look at how it all fits together.

- Implement the Recovery Strategy as an umbrella theme and tie improvement and coaching into this theme where possible
- Outline and communicate to staff what we want to achieve.
- Better use of social media / better use of communications
- Develop a 'Kaizen Mind' – everyone can spot problems with a mind to resolving through proper improvement.
- Further develop leadership skills for managers and further embed coaching work.

3.3 A whole group summary discussion took place at the end of the workshop and there was a strong consensus that the TEWV Way is an important piece of work that requires attention and action. The themes of co-production, recovery, staff development, coaching and quality improvement were echoed around the room.

4. Next Steps

4.1 It was felt by those present at the workshop that there should be further work in this area to include the following:

4.1.1 To acknowledge that consideration about further planning and implementation of the two years TEWV Way Business Plan priority, particularly in respect of 2018/19, will be required given the potential scale and scope of activity and that the process followed will be iterative in nature with annual priorities

4.1.2 To seek views about identifying a new name for this Business Plan priority, perhaps using the title of 'Making a Difference Together'.

4.1.3 To hold a series of face to face values, behaviours and staff compact consultation events. The events will be used to gather views and feedback from staff, service users, carers and governors in all localities and commissioners and local authorities and will include the use of crowdsourcing. These activities will take place during the period September to November 2017. The face to face consultation sessions will be organised and facilitated by a combination of the OD Team and those individuals who volunteered to participate during the workshop. Board members will be welcome to attend these events and to assist with facilitation should they wish to do so.

4.1.4 Though the values and behaviours consultation exercise is not being undertaken with the express intention of changing the values and behaviours statements/staff compact it is proposed that should the exercise highlight the benefit of making changes then changes will be recommended to the Board of Directors.

4.1.5 It is proposed that the Executive Management Team and the Board of Directors receive a report of the outcomes/recommendations of this consultation exercise in January 2018 and it is hoped to include any related findings arising from the Investors in People assessment (November 2017) and the participation of TEWV in a staff engagement

research project that is being undertaken by the Point of Care Foundation on behalf of the Health Foundation.

5. IMPLICATIONS

5.1 **Compliance with the CQC Fundamental Standards:**
There are no issues with the CQC fundamental standards.

5.2 **Financial/Value for Money:**

5.3 **Legal and Constitutional (including the NHS Constitution):**
There are no legal and constitutional implications/risks relating to this paper.

5.4 **Equality and Diversity:**
There are no equality and diversity implications//risks relating to this paper.

5.5 Other Implications
There are no other implications associated with this paper.

5.6 Risks
There are no risks associated with this paper.

6. CONCLUSIONS:

6.1 There was a strong feeling at the workshop that the TEWV Way Business Plan priority will be a worthwhile piece of work but that an alternative name to that of the TEWV Way ought to be used. In addition there was a strong consensus amongst workshop participants that the values and behaviours consultation exercise ought to be undertaken on the basis that there could be changes made to these statements in response to the consultation exercise feedback.

7. RECOMMENDATIONS:

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

7.2 To endorse the proposals described within section 4 of this paper.

7.3 To receive an update report in January 2018.

Paul McCourt
Operational Support Manager

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Statement of values and behaviours

Commitment to quality

We demonstrate excellence in all of our activities to improve outcomes and experiences for users of our services, their carers and families and staff.

Behaviours:

- Put service users first.
- Seek and act on feedback from service users, carers and staff about their experiences.
- Clarify people's needs and expectations and strive to ensure they are exceeded.
- Improve standards through training, experience, audit and evidence based practice.
- Learn from mistakes when things go wrong and build upon successes.
- Produce and share information that meets the needs of all individuals and their circumstances.
- Do what you / we say we are going to do.
- Strive to eliminate waste and minimise non-value adding activities.

Respect

We listen to and consider everyone's views and contributions, maintaining respect at all times and treating others as we would expect to be treated ourselves.

Behaviours:

- Be accessible, approachable and professional.
- Consider the needs and views of others.
- Be open and honest about how decisions are made.
- Observe the confidential nature of information and circumstances as appropriate.
- Be prepared to challenge discrimination and inappropriate behaviour.
- Ask for feedback about how well views are being respected.
- Consider the communication needs of others and provide a range of opportunities to access information.

Involvement

We engage with staff, users of our services, their carers and families, governors, members, GPs and partner organisations so that they can contribute to decision making.

Behaviours:

- Encourage people to share their ideas.
- Engage people through effective consultation and communication.
- Listen to what is said, be responsive and help people make choices.
- Provide clear information and support to improve understanding.
- Embrace involvement and the contribution that everyone can bring.
- Acknowledge and promote mutual interests and the contributions that we can all make at as early a stage as possible.
- Be clear about the rights and responsibilities of those involved.

Wellbeing

We promote and support the wellbeing of users of our services, their carers, families and staff.

Behaviours:

- Demonstrate responsibility for our own, as well as others, wellbeing.
- Demonstrate understanding of individual and collective needs.
- Respond to needs in a timely and sensitive manner or direct to those who can help.
- Be pro-active toward addressing wellbeing issues.

Teamwork

Team work is vital for us to meet the needs and exceed the expectations of people who use our services. This not only relates to teams within Tees, Esk and Wear Valleys NHS Foundation Trust, but also the way we work with GPs and partner organisations.

Behaviours:

- Be clear about what needs to be achieved and take appropriate ownership.
- Communicate well by being open, listening and sharing.
- Consider the needs and views of others.
- Be supportive to other members of the team.
- Be helpful.
- Fulfil one's own responsibilities.
- Always help the team and its members be successful.

Staff compact

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

The psychological or cultural relationship that exists between staff and the trust

Trust	Staff
Communications The trust will strive to ensure honest and timely communications at all times.	**Alignment** To work in accordance with the values of the trust and its strategic goals, mission (purpose) and vision.
Recognition The trust will recognise staff who have achieved excellence and show commitment to value adding work.	**Responsive** To respond to the changing needs of patients and people who use our services, as well as changes to the requirements of other "customers" and changes in demand for services.
Training and development The trust will invest in the continuing professional development, training and education of staff in the skills and competencies required and adhere to all agreed training commitments.	**Technical expertise** To keep skills and competencies up to date and relevant to their work, all of which will be evidence based.
Support The trust will ensure that staff will be involved in and supported through the process of change and managing the process of change.	**Embrace and engage** Willingness to support, co-operate with and contribute to quality improvement activities and especially with the testing of new ideas and innovations.
Work environment The trust will strive to provide a positive, healthy workplace for all staff which is characterised by enthusiasm and not cynicism; staff having the right equipment; the right colleagues and a good physical environment in which to work.	**Team work** To be supportive, positive and a good communicator with staff, people who use our services and all other "customers" e.g. GPs, CCGs, Social Services, etc.
Choice The trust will give staff choices to ensure no compulsory redundancies should job numbers reduce as a consequence of quality improvement activities.	**Flexibility** In the context of significant change taking place in society and the NHS, staff will be flexible with regard to the breadth of work undertaken and the location of their work.
"The trust will endeavour to be a great organisation to work for"	***"My job is to provide the best possible customer experience"***

making a difference together

Commitment to quality

We demonstrate excellence in all of our activities to improve outcomes and experiences for users of our services, their carers and families and staff.

Behaviours:

- Put service users first
- Seek and act on feedback from service users, carers and staff about their experiences
- Clarify people's needs and expectations and strive to ensure they are exceeded
- Improve standards through training, experience, audit and evidence based practice
- Learn from mistakes when things go wrong and build upon successes
- Produce and share information that meets the needs of all individuals and their circumstances
- Do what you / we say we are going to do
- Strive to eliminate waste and minimise non-value adding activities

Respect

We listen to and consider everyone's views and contributions, maintaining respect at all times and treating others as we would expect to be treated ourselves.

Behaviours:

- Be accessible, approachable and professional
- Consider the needs and views of others
- Be open and honest about how decisions are made
- Observe the confidential nature of information and circumstances as appropriate
- Be prepared to challenge discrimination and inappropriate behaviour
- Ask for feedback about how well views are being respected
- Consider the communication needs of others and provide a range of opportunities to access information

Involvement

We engage with staff, users of our services, their carers and families, governors, members, GPs and partner organisations, so that they can contribute to decision making.

Behaviours:

- Encourage people to share their ideas
- Engage people through effective consultation and communication
- Listen to what is said, be responsive and help people make choices
- Provide clear information and support to improve understanding
- Embrace involvement and the contribution that everyone can bring
- Acknowledge and promote mutual interests and the contributions that we can all make at as early a stage as possible
- Be clear about the rights and responsibilities of those involved

Wellbeing

We promote and support the wellbeing of users of our services, their carers and families and staff.

Behaviours:

- Demonstrate responsibility for our own, as well as others', wellbeing
- Demonstrate understanding of individual and collective needs
- Respond to needs in a timely and sensitive manner or direct to those who can help
- Be pro-active towards addressing wellbeing issues

Teamwork

Teamwork is vital for us to meet the needs and exceed the expectations of people who use our services. This not only relates to teams within our trust, but also the way we work with GPs and partner organisations.

Behaviours:

- Be clear about what needs to be achieved and take appropriate ownership
- Communicate well by being open, listening and sharing
- Consider the needs and views of others
- Be supportive to other members of the team
- Be helpful
- Fulfil one's own responsibilities
- Always help the team and its members be successful

Staff compact

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

The psychological or cultural relationship that exists between staff and the trust

Trust	Staff
Communications The trust will strive to ensure honest and timely communications at all times.	**Alignment** To work in accordance with the values of the trust and its strategic goals, mission (purpose) and vision.
Recognition The trust will recognise staff who have achieved excellence and show commitment to value adding work.	**Responsive** To respond to the changing needs of patients and people who use our services, as well as changes to the requirements of other "customers" and changes in demand for services.
Training and development The trust will invest in the continuing professional development, training and education of staff in the skills and competencies required and adhere to all agreed training commitments.	**Technical expertise** To keep skills and competencies up to date and relevant to their work, all of which will be evidence based.
Support The trust will ensure that staff will be involved in and supported through the process of change and managing the process of change.	**Embrace and engage** Willingness to support, co-operate with and contribute to quality improvement activities and especially with the testing of new ideas and innovations.
Work environment The trust will strive to provide a positive, healthy workplace for all staff which is characterised by enthusiasm and not cynicism; staff having the right equipment; the right colleagues and a good physical environment in which to work.	**Team work** To be supportive, positive and a good communicator with staff, people who use our services and all other "customers" e.g. GPs, PCTs, Social Services, etc.
Choice The trust will give staff choices to ensure no compulsory redundancies should job numbers reduce as a consequence of quality improvement activities.	**Flexibility** In the context of significant change taking place in society and the NHS, staff will be flexible with regard to the breadth of work undertaken and the location of their work.
"The trust will endeavour to be a great organisation to work for"	***"My job is to provide the best possible customer experience"***

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ITEM NO 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**20 July 2017**
TITLE:	**Annual report on progress on actions arising from Directors' Visits during the period June 2016 to May 2017**
REPORT OF:	**Brent Kilmurray**
REPORT FOR:	**Information**

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

Executive Summary:

Since 2005 the Board of Directors has undertaken a regular programme of Structured Board visits. These visits provide an opportunity for members of the Board to be visible, meet staff, learn about services and offer the opportunity for teams to highlight areas of good practice and to feedback on areas that require improvement.

Those participating in the visit are required to submit a short report on a proforma, which is stored on a log on the EMT shared drive. This report is the Annual Report on those actions.

Recommendations:

Board of Directors is asked to receive the Directors' Visits annual review of actions.

MEETING OF:	**Board of Directors**
DATE:	**20 July 2017**
TITLE:	**Annual report on progress on actions arising from Directors' visits during the period June 2016 to May 2017**

1. INTRODUCTION & PURPOSE:

1.1 Since 2005 the Board of Directors has undertaken a regular programme of Structured Board visits. These visits provide an opportunity for members of the Board to be visible, meet staff, learn about services and offer the opportunity for teams to highlight areas of good practice and to feedback on areas that require improvement.

1.2 Those participating in the visit are required to submit a short report on a proforma, which is stored on a log on the EMT shared drive. This report is the Annual Report on those actions.

2. BACKGROUND INFORMATION, CONTEXT AND KEY ISSUES:

2.1 At the Board of Directors meeting in May 2013 it was recognised that as this programme of visits had been under way for some considerable period of time it would be worth producing an annual review of actions to provide commentary on the actions undertaken in response to these reports and to provide assurance that these matters were being dealt with accordingly.

2.2 During the past year the visits log, with reports embedded, has been submitted to the Executive Management Team (EMT) on a monthly basis for scrutiny and monitoring. This provides assurance that actions are being followed up.

2.3 The attached log of Directors' visits from June 2016 to May 2017 shows the majority of the actions as green, having been completed. Where actions are marked amber there is a brief comment on the log and further details on all the visits can be seen on the visit reports in the Board of Directors' reading room on Board Pad.

2.4 Further to the review of the 90+ reports that have resulted from the last 12 months' visits, it is possible for us to identify some recurring themes that are fed back by visiting teams. Recurring issues and trends are:

- Issues with the Estate (particularly in York, but not exclusively)
- Access to appropriate technology (including PARIS)
- Performance of existing IT systems
- Staffing pressures and activity (increasing demand)
- The length of time to recruit to new or replacement posts
- Statutory and mandatory training information (including access to suitable premises and big enough rooms)

- The interface between various services and transitions, eg AMH to MHSOP and CAMHS to AMH.

3. IMPLICATIONS:

3.1 **Compliance with the CQC Fundamental Standards:**
Addressed in individual actions.

3.2 **Financial/Value for Money:**
Addressed in individual actions.

3.3 **Legal and Constitutional (including the NHS Constitution):**
Addressed in individual actions.

3.4 **Equality and Diversity:**
Addressed in individual actions.

3.5 **Other implications:**
Addressed in individual actions.

4. RECOMMENDATION:

Board of Directors is asked to receive the Directors' Visits annual review of actions.

Brent Kilmurray
Chief Operating Officer

DIRECTORS' VISITS LOG JUNE 2016 – MAY 2017 (June – November section)

	2.00 pm – 5.00 pm Monday 13/06/16 (Governors included)	2.00 pm – 5.00 pm Monday 11/07/16	2.00 pm – 5.00 pm Monday 08/08/16 (Governors included)	2.00 pm – 5.00 pm Monday 12/09/16	2.00 pm – 5.00 pm Monday 10/10/16 (Governors included)	2.00 pm – 5.00 pm Monday 14/11/16
Jennifer and David (L) Hugh Griffiths	**CAMHS Tier 3** **Address:** Brompton House, Northallerton	**HR Operational Team** **Address:** Flatts Lane, Middlesbrough	**Crisis and Recovery House** **Address:** 26 Middleton Road, Shildon	**Patient Safety Team and Clinical Audit Team** **Address:** Lanchester Road Hospital, Durham	**Overdale Ward and Bransdale Ward** **Address:** Roseberry Park Hospital, Middlesbrough	**Stockdale Ward and Bilsdale Ward** **Address:** Roseberry Park Hospital, Middlesbrough
Visit Reports	**VISIT Deferred - took place on 27th September 2016**					
Action Updates						
David (B) and Elizabeth Jim Tucker	**Darlington CAMHS Tier 3 and IAPT** **Address:** Mulberry Centre, DMH, Darlington	**Redcar & Cleveland MHSOP Community Team** **Address:**	**North Tees MH Liaison Service** **Address:**	**South Tees MH Liaison Service & Em MH Dept** **Address:** Roseberry Park Hospital, Middlesbrough	**Oak Ward and MHSOP CMHT** **Address:** West Park Hospital, Darlington	**Safeguarding Team and Physical Health Team** **Address:** Flatts Lane, Middlesbrough
Visit Reports		**VISIT CANCELLED at request of service**				
Action Updates						
Adele and Nick Lesley Bessant	**Farnham Ward and Tunstall Ward** **Address:** Lanchester Road Hospital, Durham	**Inpatient Team and Community Team** **Address:** The Orchards, Ripon	**Community ED Team** **Address:** Imperial Avenue, Stockton	**Cedar Ward and Rowan Ward** **Address:** Briary Wing, Northallerton	**CMHT and 1º MH Team and IAPT** **Address:** Windsor House, Harrogate	**Medical Development Team** **Address:** Roseberry Park Hospital, Middlesbrough
Visit Reports		**Visit undertaken but terminated to allow staff to deal with urgent service user issue**				**Visit rearranged to 16th January 2017** Report Awaited
Action Updates						

	2.00 pm – 5.00 pm Monday 13/06/16 (Governors included)	2.00 pm – 5.00 pm Monday 11/07/16	2.00 pm – 5.00 pm Monday 08/08/16 (Governors included)	2.00 pm – 5.00 pm Monday 12/09/16	2.00 pm – 5.00 pm Monday 10/10/16 (Governors included)	2.00 pm – 5.00 pm Monday 14/11/16
Colin/Drew and Brent Marcus Hawthorn	**Community LD Team** **Address:** Hundens Lane, Darlington	**Pharmacy Team** **Address:** West Park Hospital, Darlington	**Easington MHSOP** **Address:** The Vicarage 269 Station Road, Seaham	**LD Inpatient** **Address:** Bankfields, Middlesbrough	**IAPT Service** **Address:** The Driveway, Bootham Park Hospital, York, YO30 7BY	**Information Governance & Records Management** **Address:** Lanchester Road Hospital, Durham
Visit Reports	**VISIT CANCELLED**					**VISIT CANCELLED**
Action Updates						
Sharon and Levi Richard Simpson	**CAMHS Tier 3 Derwentside** **Address:** Consett	**Ivy, Clover & Northdale Wards** **Address:** Ridgeway, RPH, Middlesbrough	**Derwentside Affective Disorder and Derwentside MHSOP Teams** **Address:** Consett	**Planning Team and Performance Team** **Address:** Lanchester Road Hospital, Durham	**Affective Team and Psychosis Team and CRHT** **Address:** Foxrush House, Redcar	**Mallard Ward** **Address:** Ridgeway, RPH, Middlesbrough
Visit Reports						
Action Updates						
Ruth (H) and Rob David Jennings	**Adult LD Community, Teesside North. Hartlepool team** **Address:** Warren Road, Hartlepool	**Estates and Facilities Management Team** **Address:** EFM Directorate, Lanchester Road Hospital, Durham DH1 5RD	**CMHT, Acomb Garth** **Address:** 2 Oak Rise, York	**CAMHS & SW CMHT (SELBY VISIT)** **Address:** CAMHS The Cabin Flaxley Lane YO8 4DL Selby	**AMH Inpatients** **Address:** Peppermill Court, York	**Soft FM Team** **Address:** Lanchester Road Hospital, Durham DH1 5RD
Visit Reports				**Visit rearranged to 10 October 2016**		
Action Updates						

	2.00 pm – 5.00 pm Monday 13/06/16 (Governors included)	2.00 pm – 5.00 pm Monday 11/07/16	2.00 pm – 5.00 pm Monday 08/08/16 (Governors included)	2.00 pm – 5.00 pm Monday 12/09/16	2.00 pm – 5.00 pm Monday 10/10/16 (Governors included)	2.00 pm – 5.00 pm Monday 14/11/16
Patrick and Phil Barbara Matthews/ Shirley Richardson	**Durham MH Liaison Service and Durham CRHT** **Address:** Lanchester Road Hospital, Durham	**Community LD Team Hundens** **Address:** Hundens Lane, Darlington	**Easington Affective Team and Psychosis Team** **Address:** Merrick House, Peterlee	**Trust Secretary's Department** **Address:** West Park Hospital, Darlington	**MHSOP CMHT and Inpatient Ward/s** **Address:** Auckland Park Hospital, Bishop Auckland	**Affective Team and Psychosis Team** **Address:** Goodall Centre, Bishop Auckland
Visit Reports						
Action Updates						

Continued/…

DIRECTORS' VISITS LOG JUNE 2016 – MAY 2017 (December to May section)

	2.00 pm – 5.00 pm Monday 12/12/16 (Governors included)	2.00 pm – 5.00 pm Monday 09/01/17	2.00 pm – 5.00 pm Monday 13/02/17 (Governors included)	2.00 pm – 5.00 pm Monday 13/03/17	2.00 pm – 5.00 pm Monday 10/04/17 (Governors included)	2.00 pm – 5.00 pm Monday 08/05/17
Jennifer and David (L) Hugh Griffiths	**Hartlepool Affective Team** **Address:** Sovereign House, Hartlepool	**Derwentside Affective Team** **Address:**	**Volunteers Service and E & D Team** **Address:** Lanchester Road Hospital Durham	**Communications Team** **Address:** West Park Hospital Darlington	**Middlesbrough Psychosis / EIP Team** **Address:** Parkside Middlesbrough	**LD Adult Ward** **Address:** Lanchester Road Hospital, Durham
Visit Reports		Action related to Care Policy and PARIS recording requirements. These are under review and this work will be taken forward by the new Trust CPA lead when he commences in August 2017		**Visit rearranged to 3 May 2017**	**Visit rearranged to 2 June 2017**	
Action Updates						
David (B) and Elizabeth Jim Tucker	**Stockton MHSOP and Aysgarth Unit** **Address:** 163 Durham Road, Stockton	**Westerdale South** **Address:** Roseberry Park Hospital Middlesbrough	**CAMHS Tier 3** **Address:** Dragon Parade Harrogate	**Redcar CAMHS** **Address:** The Ridings Redcar	MHSOP Assessment **Address:** Cherry Tree House, York	North of Tees CRHT **Address:** Parkside Billingham
Visit Reports	**VISIT CANCELLED**					
Action Updates						
Adele and Nick Lesley Bessant/ Paul Murphy	**All Teams** **Address:** Gibraltar House, Northallerton	**CAMHS Tier 3** **Address:** Lake House Scarborough	**Darlington Psychosis Team** **Address:** West Park Hospital Darlington	**CAMHS Tier 3** **Address:** Brompton House Northallerton	**Tunstall Ward** **Address:** Lanchester Road Hospital Durham	**Danby Ward** **Address:** Cross Lane Hospital Scarborough
Visit Reports			**Visit rearranged to 3 May 2017**	**Visit rearranged to 11 May 2017**		
Action Updates						

	2.00 pm – 5.00 pm Monday 12/12/16 (Governors included)	2.00 pm – 5.00 pm Monday 09/01/17	2.00 pm – 5.00 pm Monday 13/02/17 (Governors included)	2.00 pm – 5.00 pm Monday 13/03/17	2.00 pm – 5.00 pm Monday 10/04/17 (Governors included)	2.00 pm – 5.00 pm Monday 08/05/17
Drew and Brent Marcus Hawthorn	**York CLDT** **Address:** Systems House House, Amy Johnson Way,Clifton Moor,**York** YO30 4XT	**Sedgefield Affective Team.** **Address:** Enterprise House, Spennymoor, Co Durham, DL16 6JF	**Kirkdale Ward** **Address:** Roseberry Park Hospital Middlesbrough	**Central Nurse Bank** **Address:** Roseberry Park Hospital Middlesbrough	**Eagle/Osprey** **Address:** Roseberry Park Hospital Middlesbrough	**Elm Ward** **Address:** West Park Hospital Darlington
Visit Reports					**Visit rearranged to 7 July 2017**	
Action Updates						
Sharon and Levi Richard Simpson	**Middlesbrough MHSOP CMHT** **Address:** Woodside, Middlesbrough	**Kestrel / Kite Wards** **Address:** Roseberry Park Hospital Middlesbrough	**CMHT NE Adult** **Address:** Bootham Park Hospital York	**Oakwood** **Address:** Belle Vue Grove Middlesbrough	**Evergreen FT** **Address:** West Lane Hospital Middlesbrough	**Northdale Ward** **Address:** Roseberry Park Hospital Middlesbrough
Visit Reports						**Visit rearranged to 5 June 2017** Action regarding TV volume in the quiet room was unclear. Paul Cartmell will discuss at the next patients' meeting.
Action Updates						
Ruth (H) and Rob David Jennings	**R&C CLDT** **Address:**	**CAMHS Tier 3** **Address:** Lime Trees York	**Harrier / Hawk Wards** **Address:** Roseberry Park Hospital Middlesbrough	**MHSOP Inpatient** **Address:** Acomb Garth York	**Oak Ward** **Address:** West Park Hospital Darlington	**Assertive Outreach Team** **Address:** 22 The Avenue York
Visit Reports						Action relates to implications for the team from the transition to Huntington House. Operational issues will continue to be raised and worked through as part of the arrangements for the move.
Action Updates						

	2.00 pm – 5.00 pm Monday 12/12/16 (Governors included)	2.00 pm – 5.00 pm Monday 09/01/17	2.00 pm – 5.00 pm Monday 13/02/17 (Governors included)	2.00 pm – 5.00 pm Monday 13/03/17	2.00 pm – 5.00 pm Monday 10/04/17 (Governors included)	2.00 pm – 5.00 pm Monday 08/05/17
Patrick and Phil Shirley Richardson	**AMH Whitby and MHSOP Whitby** **Address:** The Anchorage, Whitby	**Darlington Affective Team** **Address:** West Park Hospital Darlington	**Mental Health Act Team** **Address:** Roseberry Park Hospital	**North Durham Psychosis Team** **Address:** Chester Le Street	**Harrogate CLDT** **Address:** Alexander House Knaresborough	**KPO Team** **Address:** Lanchester Road Hospital Durham
Visit Reports						
Action Updates						

Item 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**20 July 2017**
TITLE:	**Finance Report for Period 1 April 2017 to 30 June 2017**
REPORT OF:	**Drew Kendall, Interim Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The comprehensive income outturn for the period ending 30 June 2017 is a surplus of £2,774k, representing 3.3% of the Trust's turnover and is £8k ahead of plan.

Identified Cash Releasing Efficiency Savings at 30 June 2017 are £344k behind plan however the Trust continues to identify and develop schemes to ensure full delivery of CRES for current and future years.

The Use of Resources Rating for the Trust is assessed as 2 for the period ending 30 June 2017 and is behind plan due to agency expenditure being £66k higher than planned. The rating is forecast to improve to a 1 by the end of the financial year.

Recommendations:

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

The Board of Directors is requested to approve the submission of the NHS Improvement quarter 1 return in accordance with the results detailed in this report.

MEETING OF:	**Board of Directors**
DATE:	**20 July 2017**
TITLE:	**Finance Report for Period 1 April 2017 to 30 June 2017**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2017 to 30 June 2017.

2. BACKGROUND INFORMATION

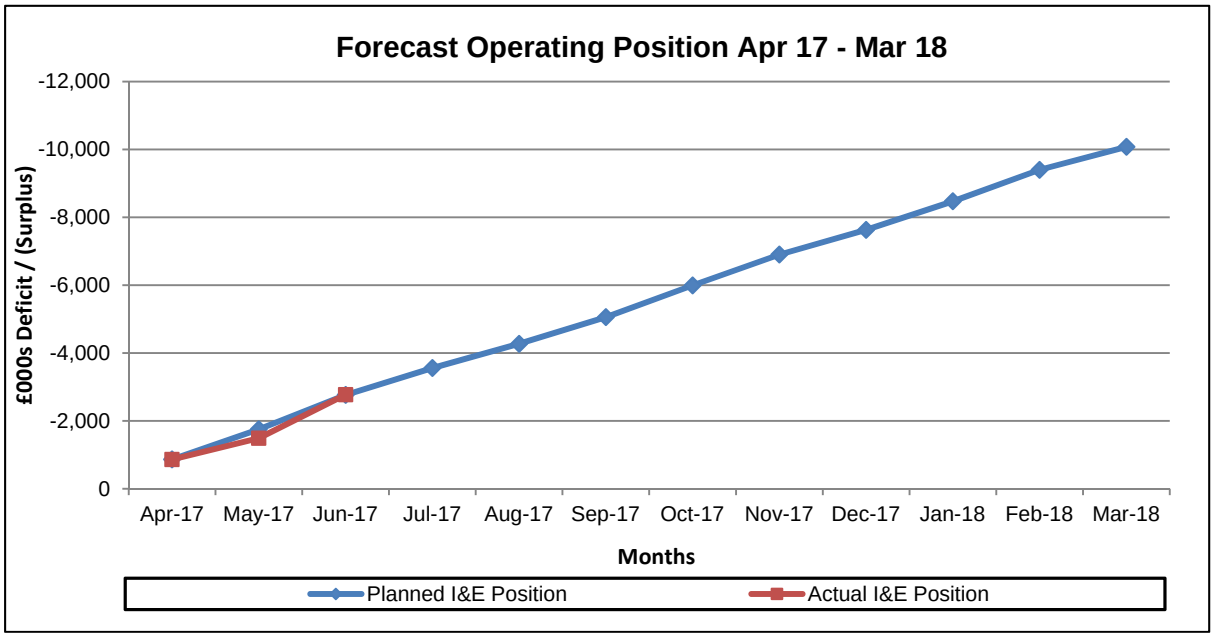
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

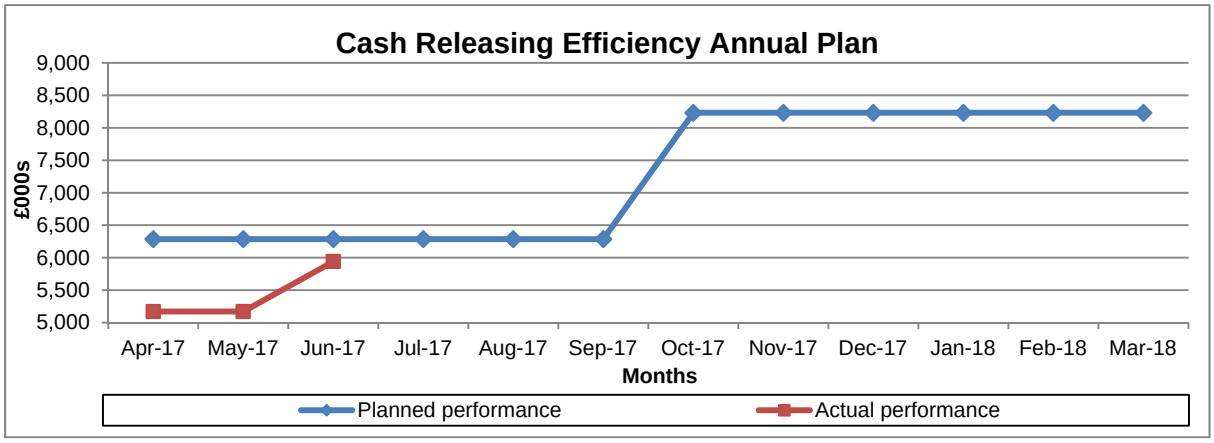
The comprehensive income outturn for the period ending 30 June 2017 is a surplus of £2,774k, representing 3.3% of the Trust's turnover and is £8k ahead of plan.

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

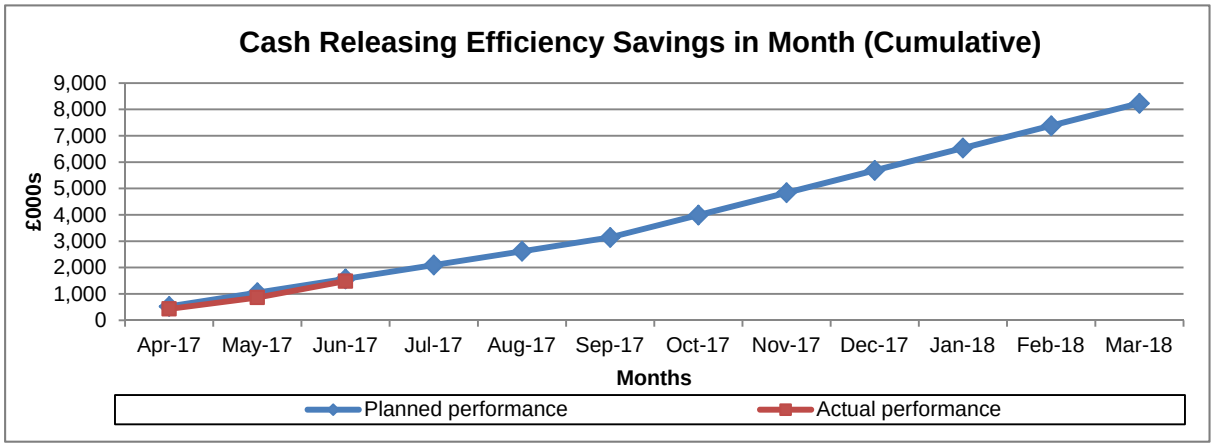


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 30 June 2017 is £5,940k and is £344k behind plan, though the Trust continues to identify and progress schemes to deliver CRES in full for current and future years.

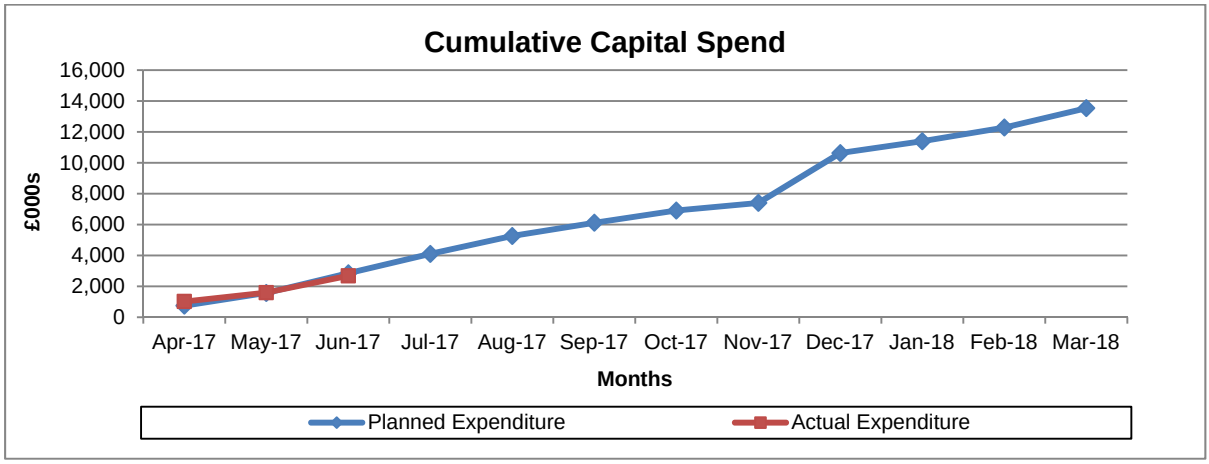


The monthly profile for CRES identified by Localities is shown below.



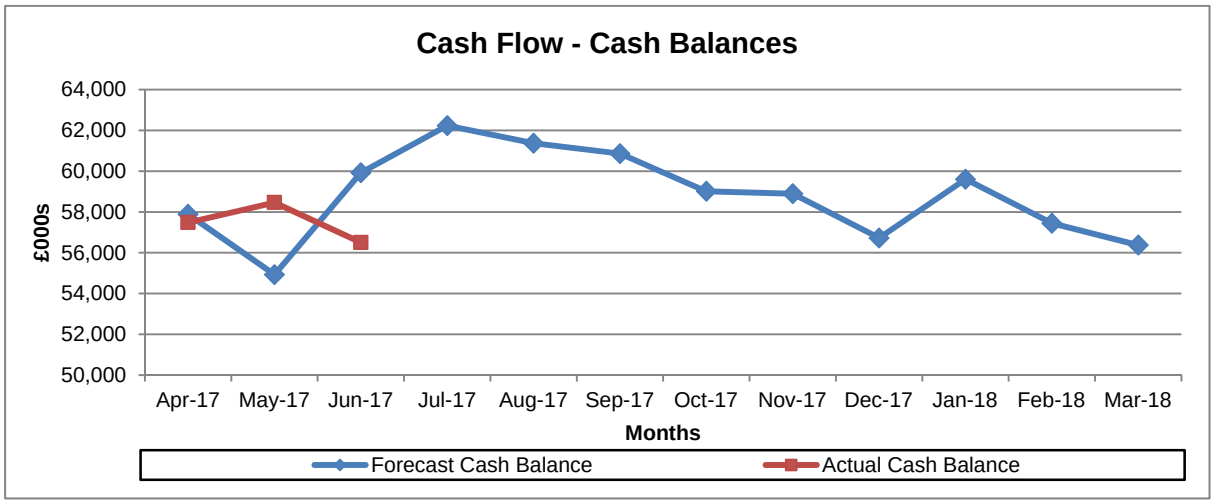
3.3 Capital Programme

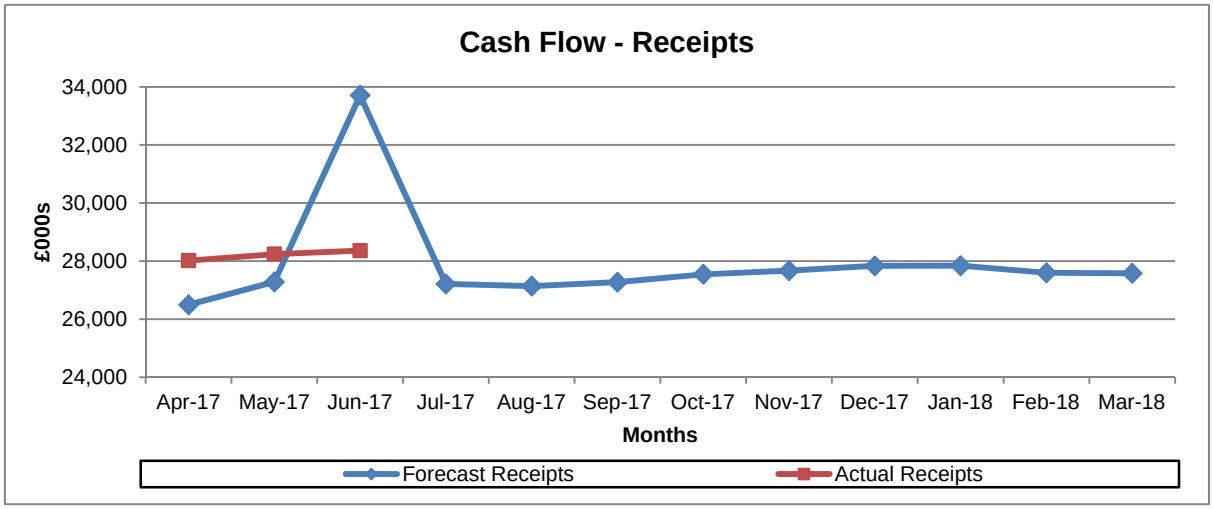
Capital expenditure to 30 June 2017 is £2,682k and is £165k behind plan due to minor delays against identified developments.

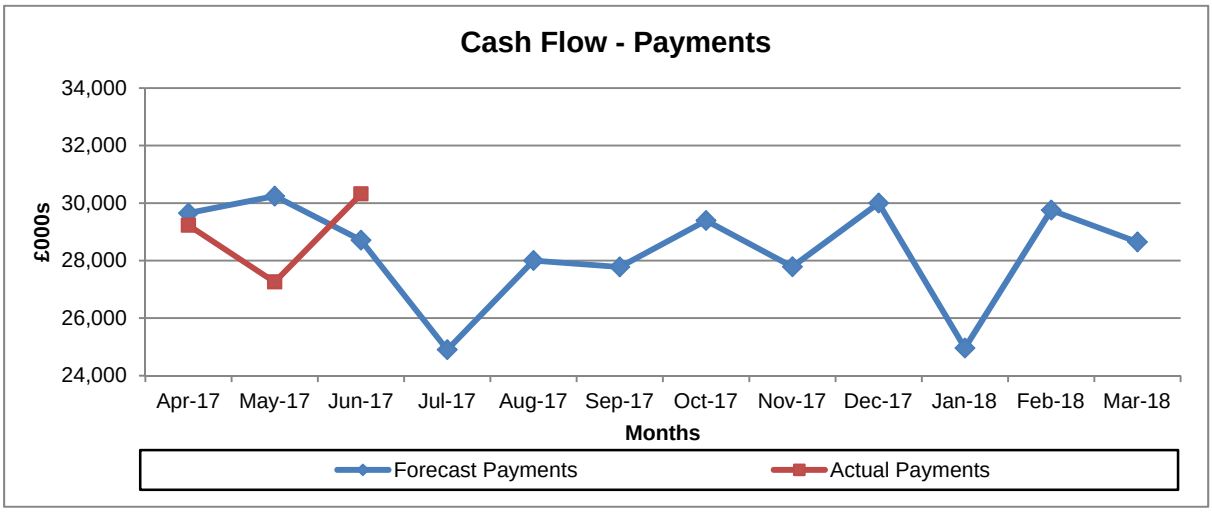


3.4 Cash Flow

Total cash at 30 June 2017 is £56,507k, and is £3,418k behind plan due to the Trust not receiving payment of 2016/17 incentivised Sustainability and Transformational Fund (STF) as planned. This is partially offset by working capital variations. STF payment is now expected in July 2017.



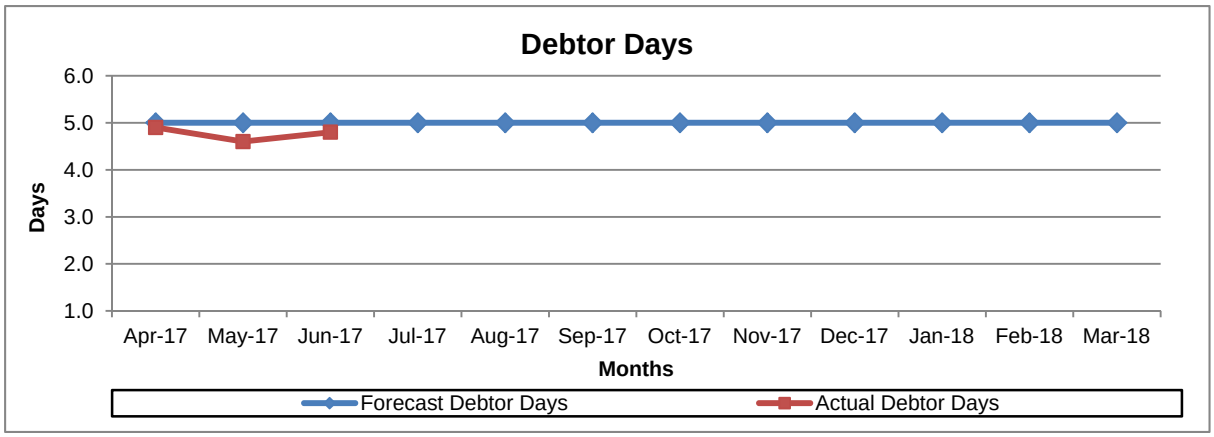




The payments profile fluctuates over the year for 2016/17 Sustainability and Transformation Fund incentive scheme receipt (June), PDC dividend payments, financing repayments and capital expenditure.

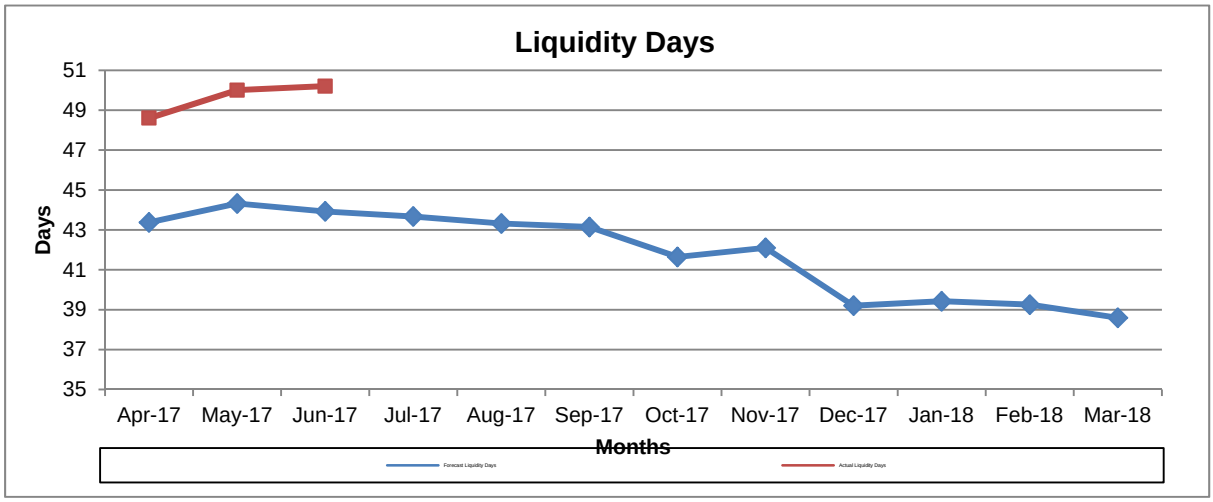
Working Capital ratios for period to 30 June 2017 are:

- Debtor Days of 4.8 days
- Liquidity of 50.2 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 59.73%
  Non NHS 30 Days – 97.06%



The Trust has a debtors' target of 5.0 days, and actual performance of 4.8 days at 30 June 2017, which is ahead of plan.

The liquidity days graph below reflects the metric within NHS Improvement's single oversight framework. The Trust's liquidity day's ratio is ahead of plan due to higher than planned net current assets.



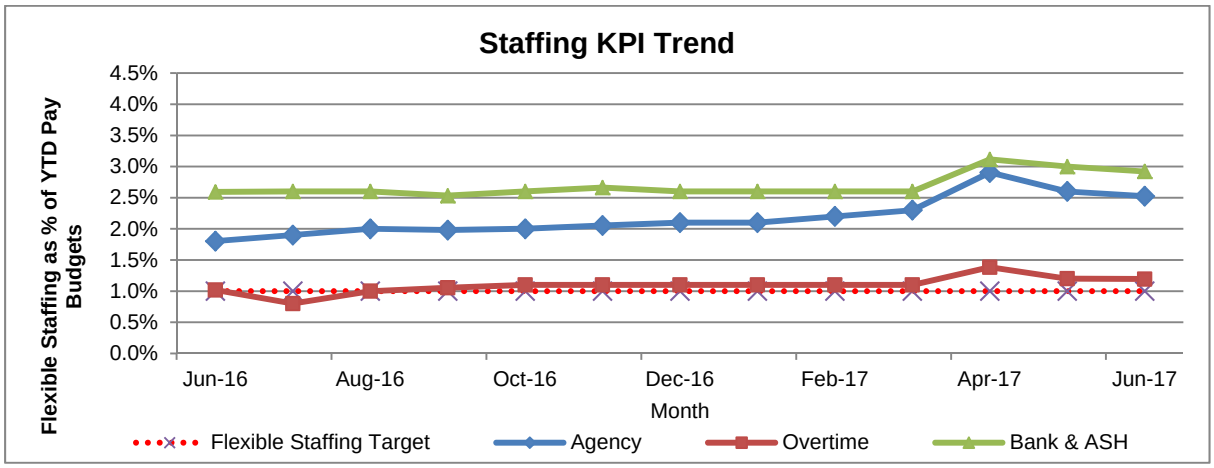
3.5 Financial Drivers

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

Tolerance	Jan	Feb	Mar	Apr	May	June
Agency (1%)	2.1%	2.2%	2.3%	2.9%	2.6%	2.5%
Overtime (1%)	1.1%	1.1%	1.1%	1.4%	1.2%	1.2%
Bank & ASH (flexed against establishment)	2.6%	2.6%	2.6%	3.1%	3.0%	2.9%
Establishment (90%-95%)	93.5%	93.9%	93.7%	94.6%	94.0%	94.2%
Total	**99.3%**	**99.8%**	**99.8%**	**102.0%**	**100.8%**	**100.9%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for agency and overtime, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For June 2017 the tolerance for Bank and ASH is 3.8% of pay budgets.

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



Additional staffing expenditure is 6.6% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (40%), service need (23%), enhanced observations (18%) and sickness (11%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating is assessed as 2 at 30 June 2017, and is behind plan. The rating is forecast to improve to a 1 by the end of the financial year.

3.6.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.45x (can cover debt payments due 1.45 times), which is ahead of plan and rated as a 3.

3.6.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 50.2 days, this is ahead of plan and is rated as a 1.

3.6.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 3.3% and is rated as a 1.

3.6.5 The variance from control total assesses the I&E Margin against plan, excluding STF income. The Trust I&E Margin is 0.1% behind plan and is rated as a 2.

3.6.6 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is higher than the cap and is rated as a 2.

The margins on Use of Resource Rating are as follows:

- Capital service cover - to increase to a 2 a surplus increase of £1,343k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £42,453k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £1,945k is required.
- Variance from control total from plan – to increase to a 1 an operating surplus decrease of £61k is required.
- Agency Cap rating – to increase to a 1 a reduction in agency expenditure of £66k is required.

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

TEWV Performance	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	1.45x	3	1.35x	3	
Liquidity	50.2 days	1	43.9 days	1	
I&E margin	3.3%	1	3.4%	1	
Variance from control total	0.1%	2	0.0%	1	
Agency expenditure	£1,608k	2	£1,542k	1	
Overall Use of Resource Rating		**2**		**1**	

3.6.7 11.5% of total receivables (£493k) are over 90 days past their due date. This is above the 5% finance risk tolerance, but is not a cause for concern as £261k of debts are supported by a SLA and discussions to resolve debts have been positive.

Excluding debts supported by an SLA the ratio reduces to 5.4%.

3.6.8 3.9% of total payables invoices (£464k) held for payment are over 90 days past their due date. This is within the 5% finance risk tolerance.

3.6.9 The cash balance at 30 June 2017 is £56,507 and represents 66.1 days of annualised operating expenses.

3.6.10 The Trust does not anticipate the Use of Resources rating to be below a 2 beyond quarter 1, as per its annual plan.

4. IMPLICATIONS:

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

5. RISKS:

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

6. CONCLUSIONS:

6.1 The comprehensive income outturn for the period ending 30 June 2017 is a surplus of £2,774k, representing 3.3% of the Trust's turnover and is £8k ahead of plan.

6.2 Identified Cash Releasing Efficiency Savings at 30 June 2017 are £344k behind plan however the Trust continues to identify and develop schemes to ensure full delivery of CRES for current and future years.

6.3 The Use of Resources Rating for the Trust is a 2 for the period ending 30 June 2017 which is behind plan. The rating is forecast to improve to a 1 by the end of the financial year.

7. RECOMMENDATIONS:

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

7.2 The Board of Directors is requested to approve the submission of the NHS Improvement quarter 1 return in accordance with the results detailed in this report.

Drew Kendall
Interim Director of Finance and Information

ITEM NO.11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**20TH July 2017**
TITLE:	**Quarterly Workforce Report as at 30TH June 2017**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Information**

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

Executive Summary:

The report provides information about non-medical and medical workforce performance during the first quarter of 2017/18 along with information about the latest Staff Friends and Family Test results.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**20TH July 2017**
TITLE:	**Quarterly Workforce Report as at 30TH June 2017**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide Directors with information about key workforce performance. Non-medical workforce information for the period April to June 2017 is provided within Appendix 1 and medical workforce information for the same period can be found within Appendix 2. Information about the latest Staff Friends and Family Test results is provided within Appendix 3.

2. BACKGROUND INFORMATION AND CONTEXT:

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

3. KEY ISSUES:

3.1 There was a mixed position in respect of recruitment fill rates as the overall TEWV recruitment fill rate fell from 85% to 83% during the last quarter though the registered nurse recruitment fill rate increased from 83% to 88%. Medical and psychological therapy posts proved particularly challenging to fill and locality variations in recruitment fill rates are apparent across a range of different posts.

3.2 Labour turnover remained stable and within the TEWV target range with medical and nursing staff groups recording the lowest labour turnover rates. Retirement and flexible retirement have accounted for 38% of recorded reasons for leaving TEWV voluntarily during the last twelve months. The Trust has recently implemented a Retire and Return Scheme and it is hoped that this scheme will encourage more staff to consider retiring and returning to work. There remains however, a significant knowledge gap about reasons for leaving as the reasons why 22% of staff, who chose to leave TEWV voluntarily, are not known. In response to this situation with regard to nursing staff it is planned to put in place an approach whereby the respective Head of Nursing will be notified of all nurses within their locality who have given the Trust notice of their intention to leave and the Head of Nursing will offer a face to face conversation to the prospective leaver. It is estimated that there will typically be eight or nine such conversations each month. This approach ought to help us to better understand the reason(s) why nurses are leaving TEWV. The intention is that the information gathered from these conversations, and other sources such as the electronic exit questionnaire,

will be used to shape future retention related policy and practice to help TEWV improve its ability better retain nurses in the future.

3.3 A greater focus upon retention activities in the future, to complement the significant efforts that are already being made to bring more new staff into TEWV, is thought to be needed. Information obtained from electronic exit questionnaires indicates that doing more to address the issues of working conditions, flexible working and career/training opportunities could have a positive impact upon staff retention.

3.4 This quarterly report provides a particular focus upon short term sickness absence. Though good progress has been made over recent years with tackling long term sickness absence the same cannot be said about short term sickness absence. The Executive Management Team has recently agreed that further efforts are to be made to improve the management of short term sickness absence including further attempts to identify whether regular short term sickness absence can often lead to long term sickness absence, further monitoring of adherence to the TEWV sickness absence procedure, implementation of a regular audit programme and the provision of more training for managers. Should TEWV be able to reduce its average short term sickness rates to those of the north east NHS average then it would certainly be more likely that the overall TEWV sickness absence target could be achieved.

3.5 Appendix 2 provides details about key medical staffing issues including the continuing difficulties being experienced with recruitment despite the significant efforts that are being made to address both recruitment and retention.

3.6 Appendix 3 provides information about the latest Staff Friends and Family Test results, including the comments made by individual staff members when completing the survey. The response to the questions within the Staff Friends and Family Test were either similar to or a little more positive than those of the previous survey which is welcome. Unlike the previous set of results this time there were no abusive comments within the narrative. For the first time questions were included about whether staff would welcome the facilitation by TEWV of access for staff to physical activities/groups and about whether staff think that TEWV supports and values those staff that have lived experience of mental distress. The responses to the first of these questions will assist efforts to improve the physical health of TEWV staff and the second will inform one of the Recovery Strategy scorecard target baselines. Half of the respondents would be interested in TEWV facilitating access to physical activities/groups and two thirds of respondents believe that TEWV currently supports and values staff members with lived experience of mental distress. These results ought to help to provide a good basis from which to target staff support to improve physical health and to help measure the progress that is made over the coming years with implementation of the Recovery Strategy. The TEWV Organisational Development team is working with managers to support some forty teams, to varying extents, in response to Staff Friends and Family Tst results during the last year. This activity is proving to be one of a number of

constructive ways of responding to the feedback that is provided by staff.

4. IMPLICATIONS:

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

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

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

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

4.4 **Other implications:** None identified.

5. RISKS:

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

6. CONCLUSIONS:

6.1 The overall TEWV recruitment fill rate reduced during the last quarter however, progress continues to be made with increasing nurse recruitment fill rates though medical and psychological therapy are a particular concern. There is a need to increase retention related activities to complement recruitment activities for all staff groups.

6.2 There is to be a greater focus upon short term sickness absence management as it is believed that this may contribute to achieving a reduction in the overall level of sickness absence within TEWV.

6.3 The Staff Friends and Family Test results suggest that TEWV remains a good place to work though some variations between teams and locality results are present.

7. RECOMMENDATIONS:

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

David Levy
Director of Human Resources and Organisational Development

Background Papers:

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

APPENDIX 1

HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT DIRECTORATE

QUARTERLY WORKFORCE REPORT APRIL TO JUNE 2017

1.0 INTRODUCTION

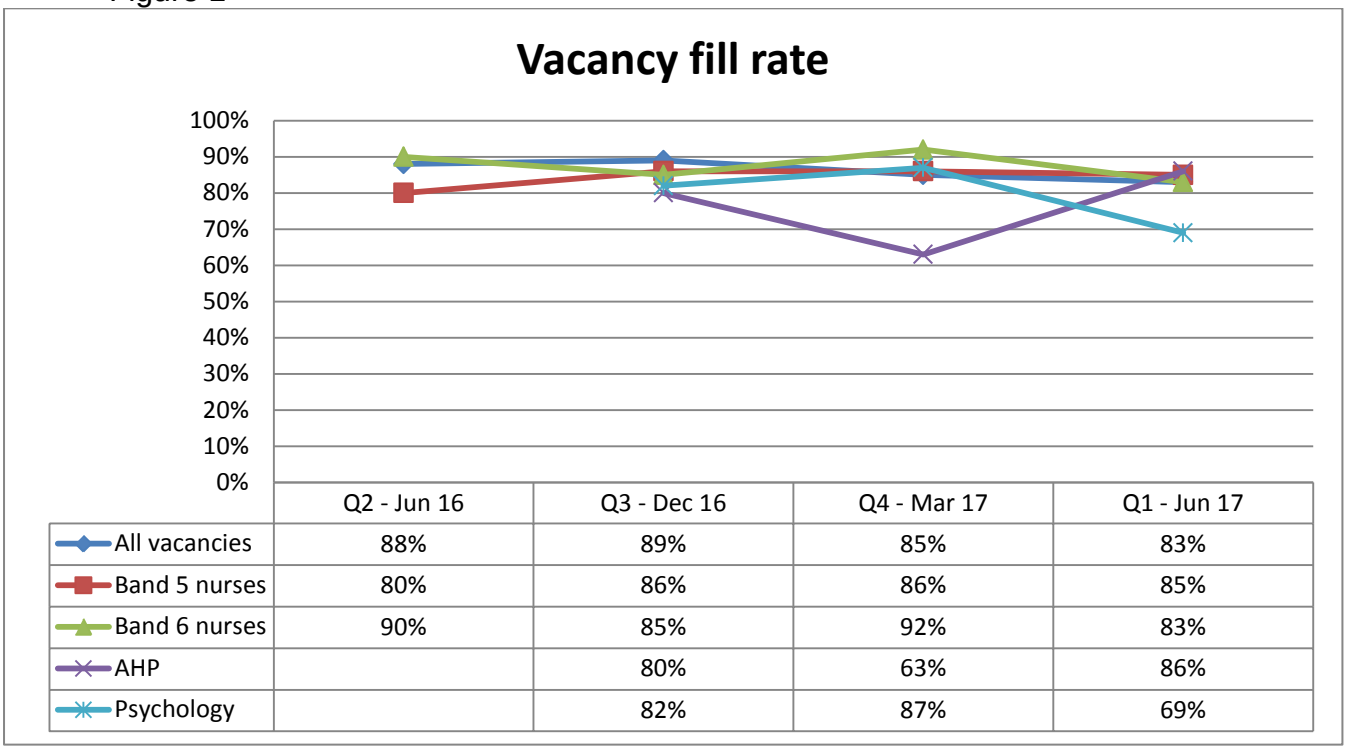
1.1 This report provides detailed analysis on a range of workforce related activities along with an update on progress towards the key HR related workforce performance indicators as at June 2017. The report will provide detailed analysis on:-

- Recruitment fill rate analysis
- Leaver analysis
- Short term sickness absence analysis

2.0 Recruitment Analysis

2.1 The total number of vacancies advertised during the reporting period was 220, with a total of 182 successful appointments made. The graph at figure 1 highlights a vacancy fill rate of **83%** which represents a reduction on the figure of 85% at quarter four. The figures are based on people being offered a post during the quarter and unfilled vacancies.

Figure 1



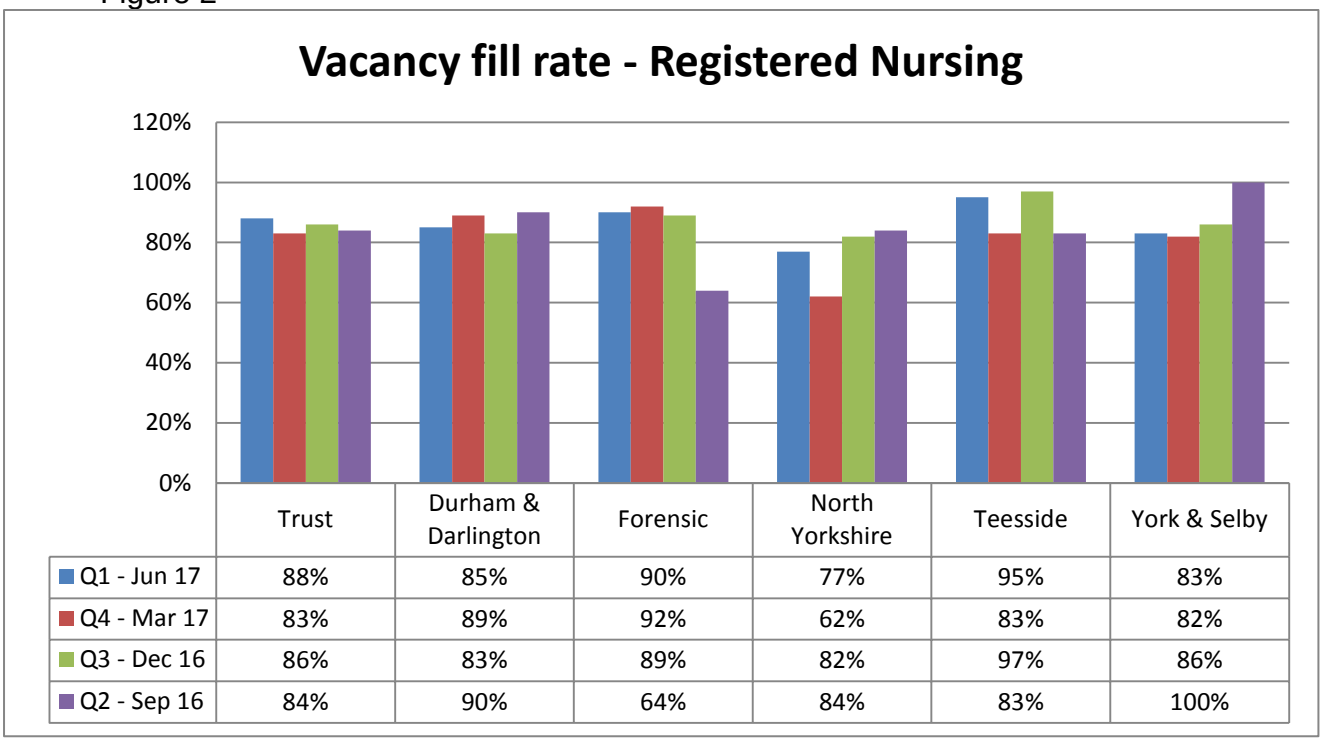
	Q2 - Jun 16	Q3 - Dec 16	Q4 - Mar 17	Q1 - Jun 17
All vacancies	88%	89%	85%	83%
Band 5 nurses	80%	86%	86%	85%
Band 6 nurses	90%	85%	92%	83%
AHP		80%	63%	86%
Psychology		82%	87%	69%

2.2 28 of the advertised vacancies were highlighted to be a readvertisement of which 23 were successfully recruited to this time. Analysis of the readvertised vacancies that remained unfilled highlight a range of posts that had proved difficult to recruit to including an Advanced Practitioner – band 7, Primary Mental Health Worker – band 6, Psychological Wellbeing Practitioner – band 5, Health Care Assistant in North Yorkshire children's services with 3 out of 5 of the vacancies being filled and Teesside Children's Team Manager – band 7.

2.3 Analysis of vacancies that remained unfilled during this quarter highlights a number of posts that proved difficult to recruit to of particular note was the difficulty being experienced in recruiting to Psychological Therapist band 7 and Psychological Wellbeing Practitioner band 5 vacancies. A total of 6 vacancies were successfully recruited to out of a total of 12 required.

2.4 The graph at figure 2 highlights the vacancy fill rate for registered nurses bands 5 – 7. The vacancy fill rate has increased to 88% during the last quarter.

Figure 2

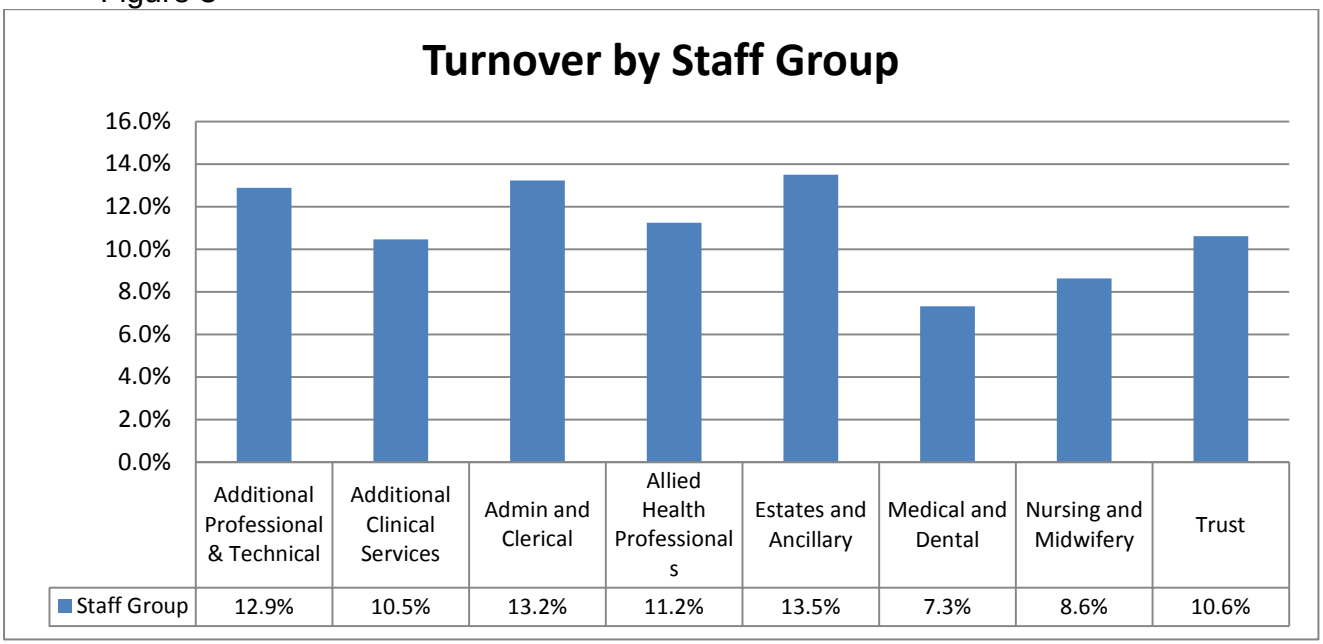


	Trust	Durham & Darlington	Forensic	North Yorkshire	Teesside	York & Selby
Q1 - Jun 17	88%	85%	90%	77%	95%	83%
Q4 - Mar 17	83%	89%	92%	62%	83%	82%
Q3 - Dec 16	86%	83%	89%	82%	97%	86%
Q2 - Sep 16	84%	90%	64%	84%	83%	100%

3.0 Leaver Analysis

3.1 The graph at figure 3 provides a breakdown of turnover by staff group. Staff categorised as Estates and Ancillary and Admin and Clerical have reported the highest level of turnover with the majority of staff leaving for voluntary reasons. The staff group Additional Professional and Technical include Psychologists and Pharmacists, analysis highlighted 24% were leaving for reasons of retirement and 27% for reasons associated with promotion, better reward package and relocation.

Figure 3



	Additional Professional & Technical	Additional Clinical Services	Admin and Clerical	Allied Health Professionals	Estates and Ancillary	Medical and Dental	Nursing and Midwifery	Trust
Staff Group	12.9%	10.5%	13.2%	11.2%	13.5%	7.3%	8.6%	10.6%

3.2 The graph at figure 4 provides a breakdown of reasons associated with voluntary resignations across the organisation over the last 12 months. 38% of resignations are attributable to retirement and flexible retirement. The graph at figure 5 provides a comparison focussing on voluntary resignation for registered nurses in bands 5 – 7. It is interesting to note that over 50% of staff are leaving for reasons of retirement and flexible retirement.

Figure 4

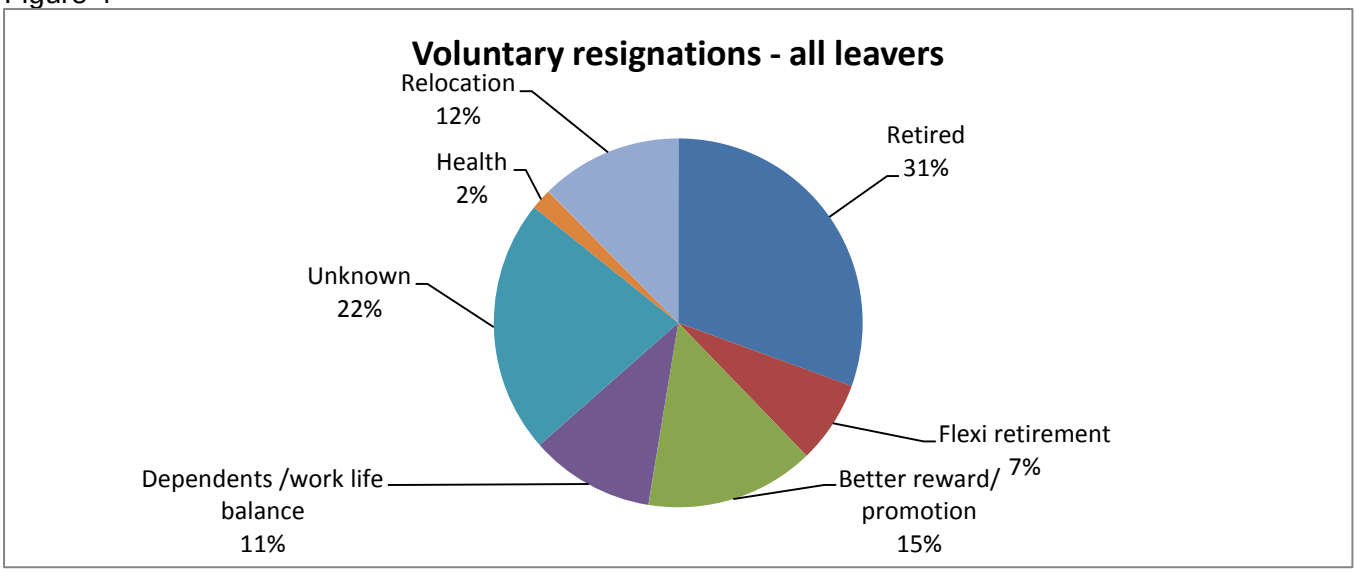
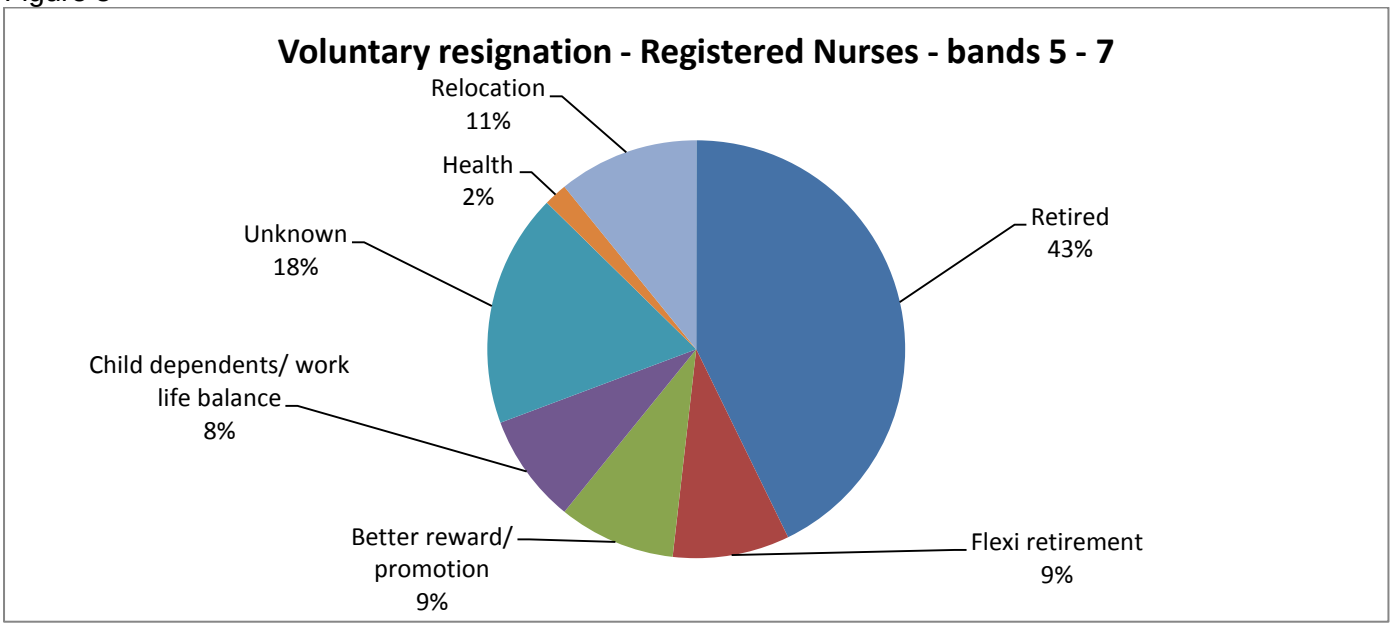
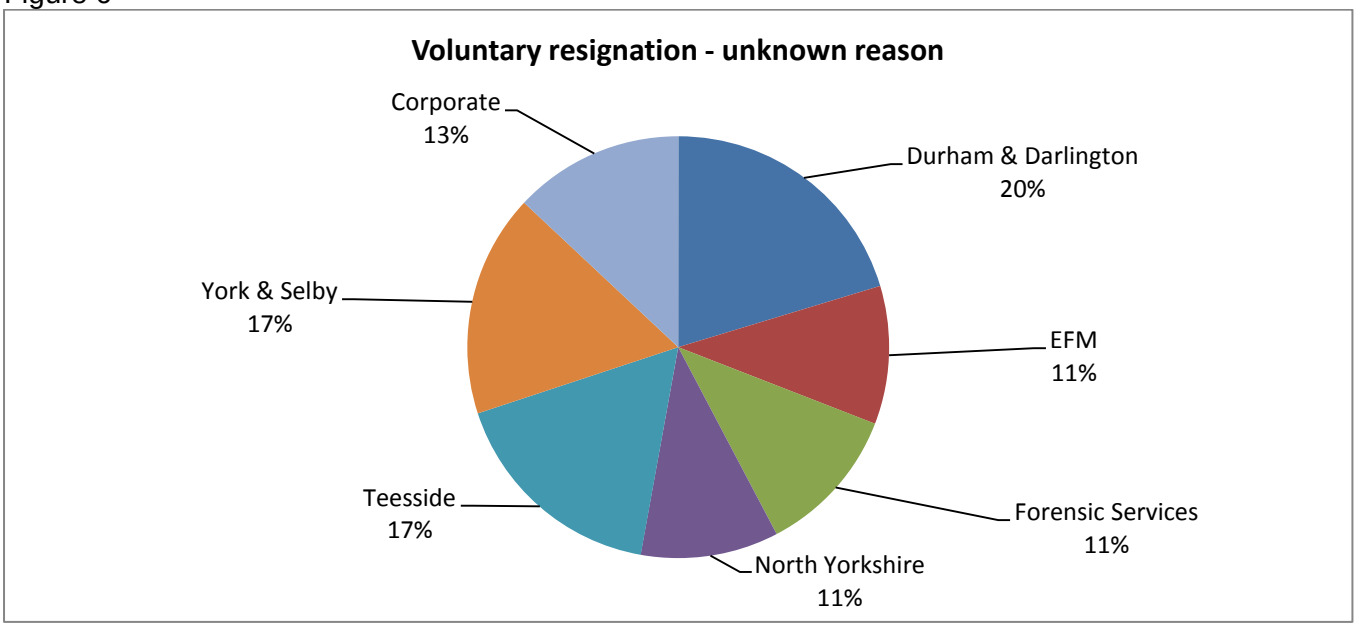


Figure 5



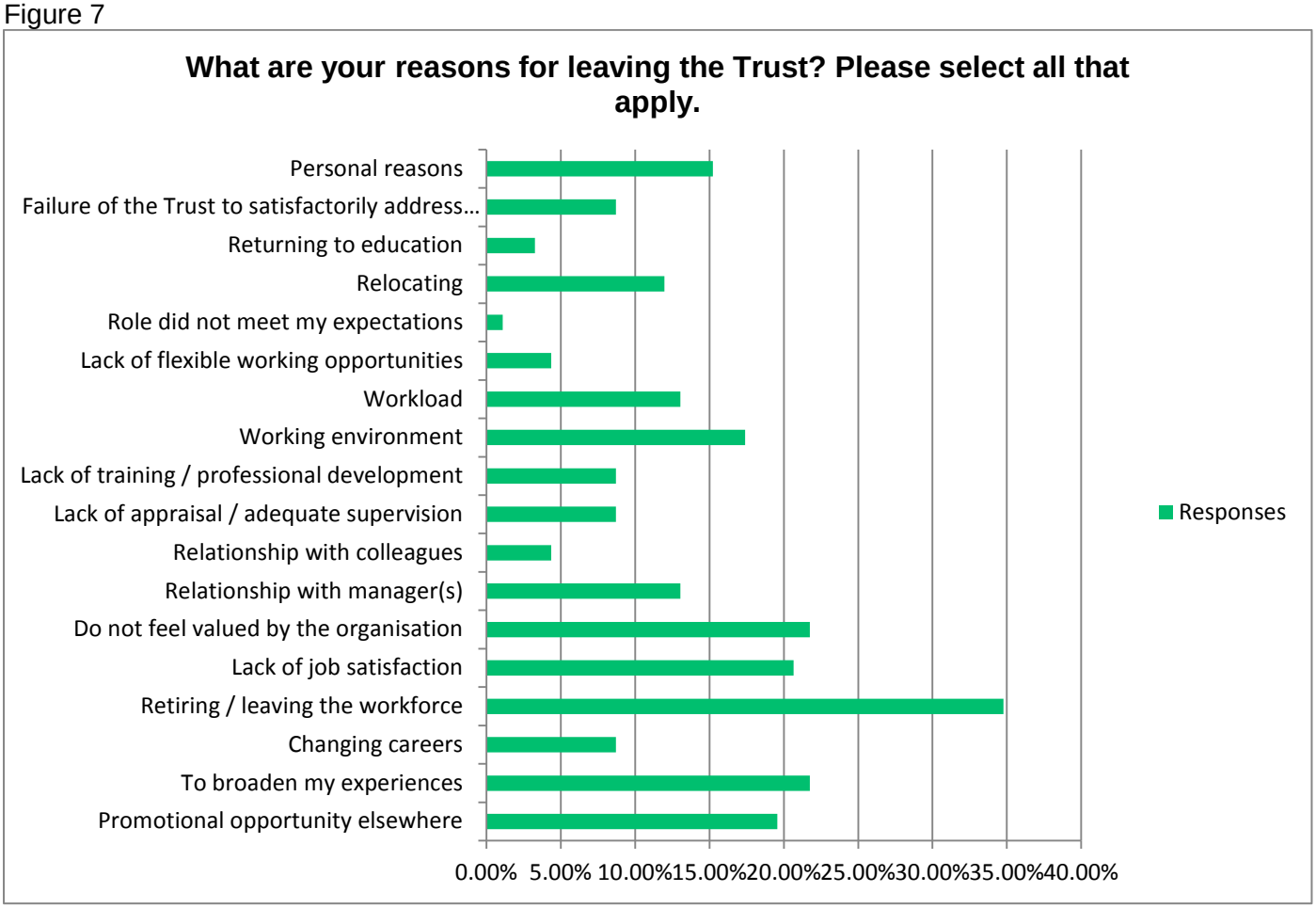
3.3 22% of leavers who have voluntarily resigned are assigned a code of unknown. The graph at figure 6 provides a breakdown of unknown reason by Locality.

Figure 6



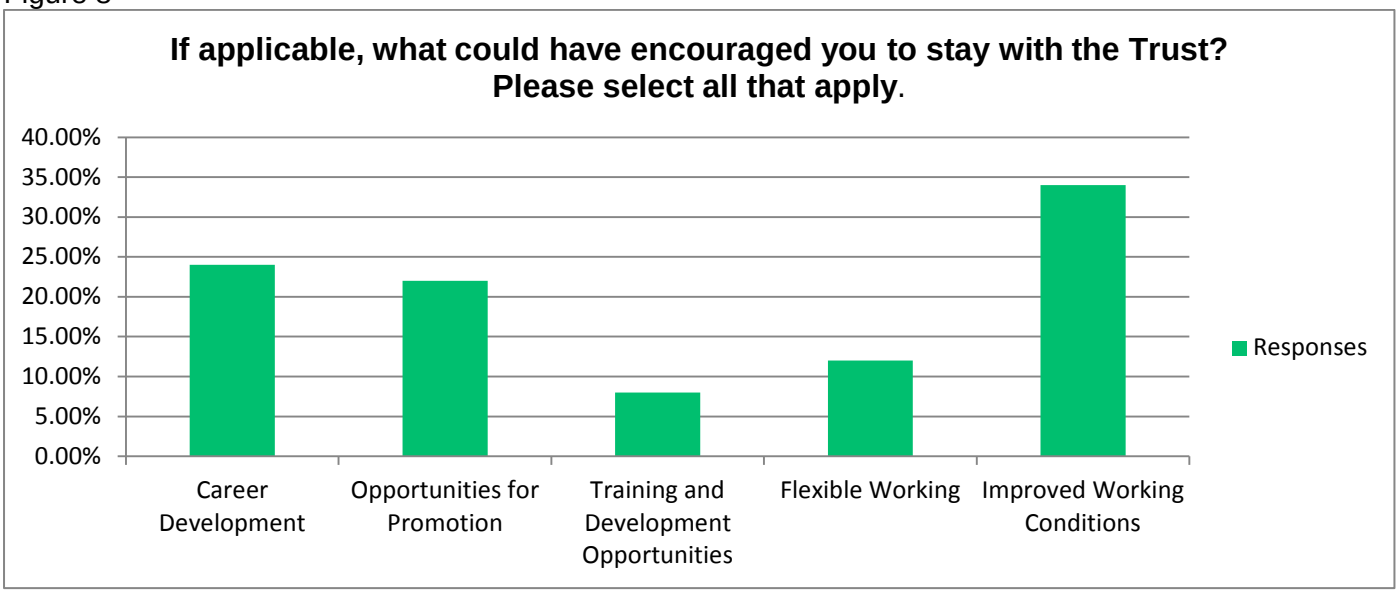
3.4. The Trust captures information from leavers via an exit questionnaire administered through survey monkey. The following graphs present responses received from January 2017 to June 2017. 97 responses were received during the reporting period. The graph at figure 7 shows 35% of respondents leaving for reasons of retirement. Respondents are able to choose more than one reason for leaving. 21.74% indicated they were leaving to broaden their experience and the same percentage indicated they did not feel valued by the organisation.

Figure 7



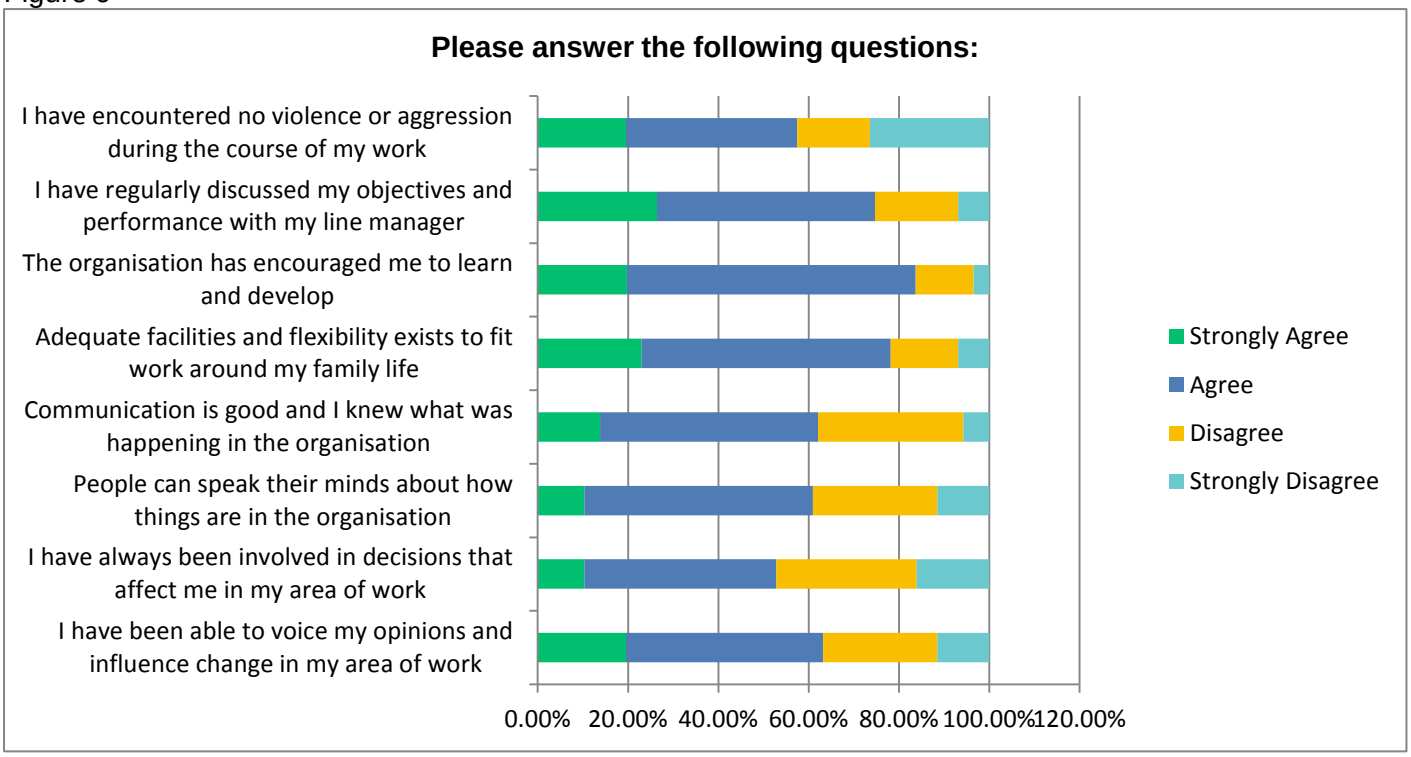
3.5 The graph at figure 8 below provides an insight into what could have encouraged the leaver to stay.

Figure 8



3.6 Figure 9 asks for views on a range of questions and provides a graded response ratio. Over 80% of leavers strongly agreed or agreed the organisation had encouraged them to learn and develop. Just over 42% indicated that they had always been involved in decisions that may affect them in their area of work.

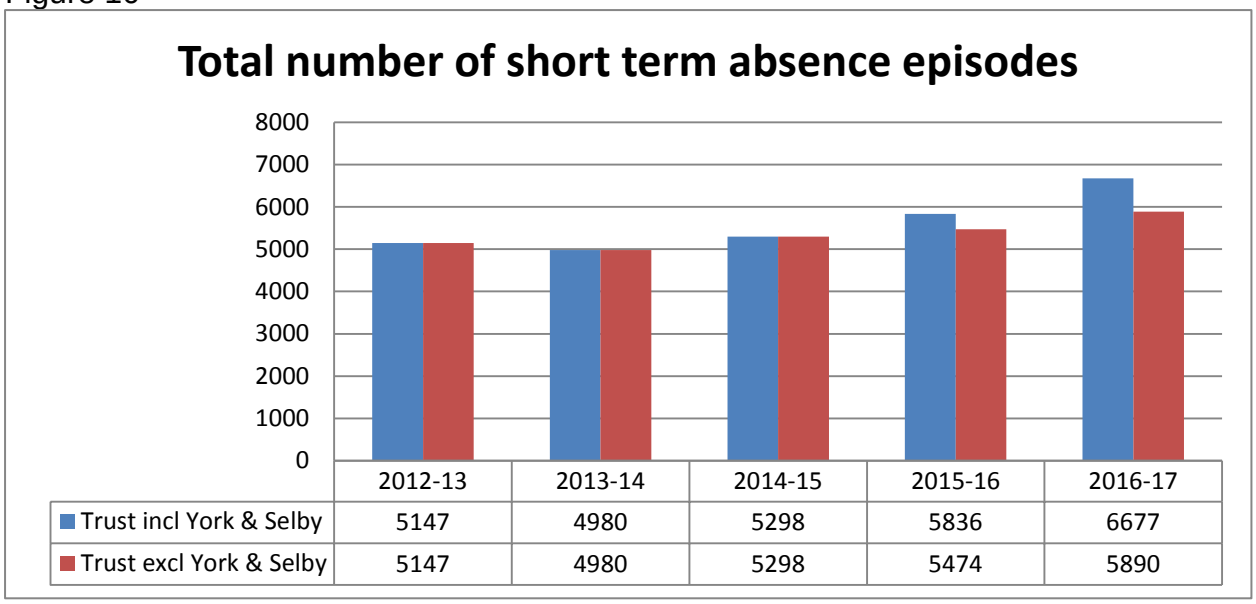
Figure 9



4.0 ANALYSIS OF SHORT TERM SICKNESS ABSENCE

4.1 Short term sickness absence is classed as a period of absence lasting between 1 to 27 days. The graph at figure 10 provides a breakdown of the total number of episodes of short term absence over a period of five years. The graph shows the figures including and excluding York and Selby. The graph highlights an increase of 7.6% in the number of episodes excluding the episodes associated with York and Selby Locality.

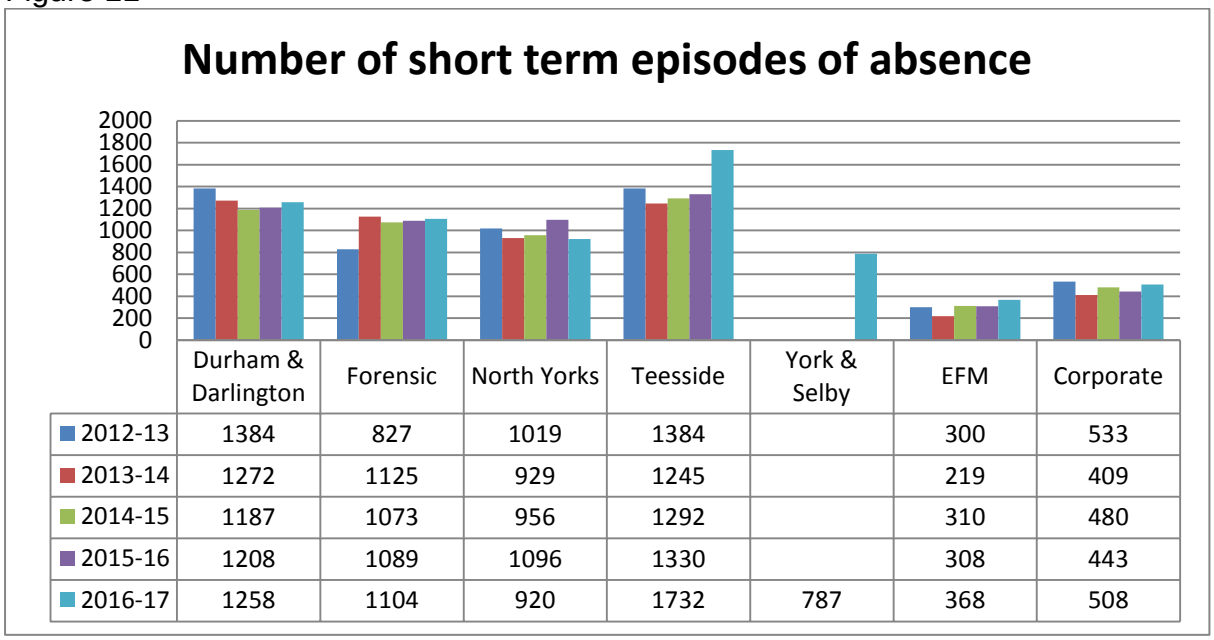
Figure 10



	2012-13	2013-14	2014-15	2015-16	2016-17
Trust incl York & Selby	5147	4980	5298	5836	6677
Trust excl York & Selby	5147	4980	5298	5474	5890

4.2 The graph at figure 11 provides a breakdown by locality of short term absence over the reporting period. All localities apart from North Yorkshire are reporting an increase in episodes of short term absence. **It should be noted that Tier 4 Children and Young People services moved from North Yorkshire Locality to Teesside Locality which may be attributable to the 16% reduction reported.** The greatest increase in episodes of short term absence is within Teesside Locality at 30%.

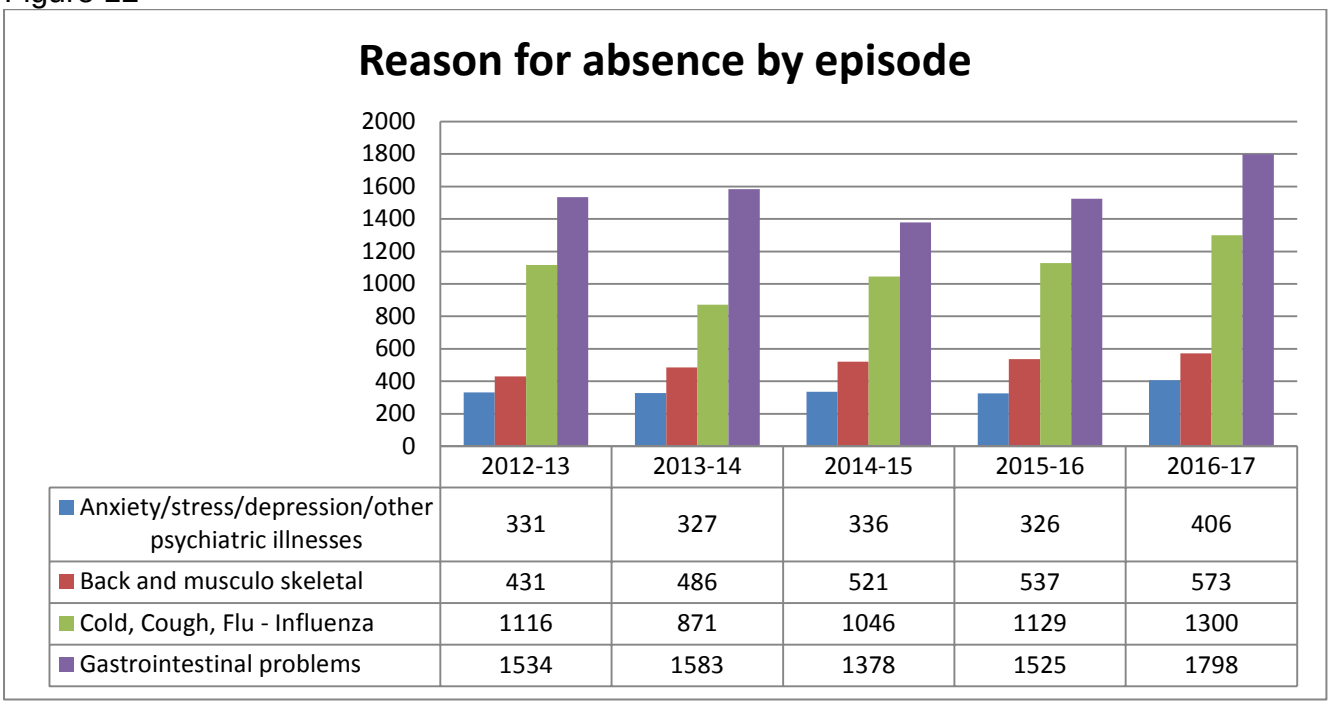
Figure 11



	Durham & Darlington	Forensic	North Yorks	Teesside	York & Selby	EFM	Corporate
2012-13	1384	827	1019	1384		300	533
2013-14	1272	1125	929	1245		219	409
2014-15	1187	1073	956	1292		310	480
2015-16	1208	1089	1096	1330		308	443
2016-17	1258	1104	920	1732	787	368	508

4.2 The graph at figure 12 highlights the four most prevalent reasons for absence by the number of episodes over the last five years. For the purposes of drawing appropriate comparisons the figures exclude York and Selby episodes. The graph highlights an increase in episodes on all of the reasons during 2016 – 17. **There is a notable increase of 24.5% in episodes associated with anxiety/stress/ depression and other psychiatric illnesses.**

Figure 12



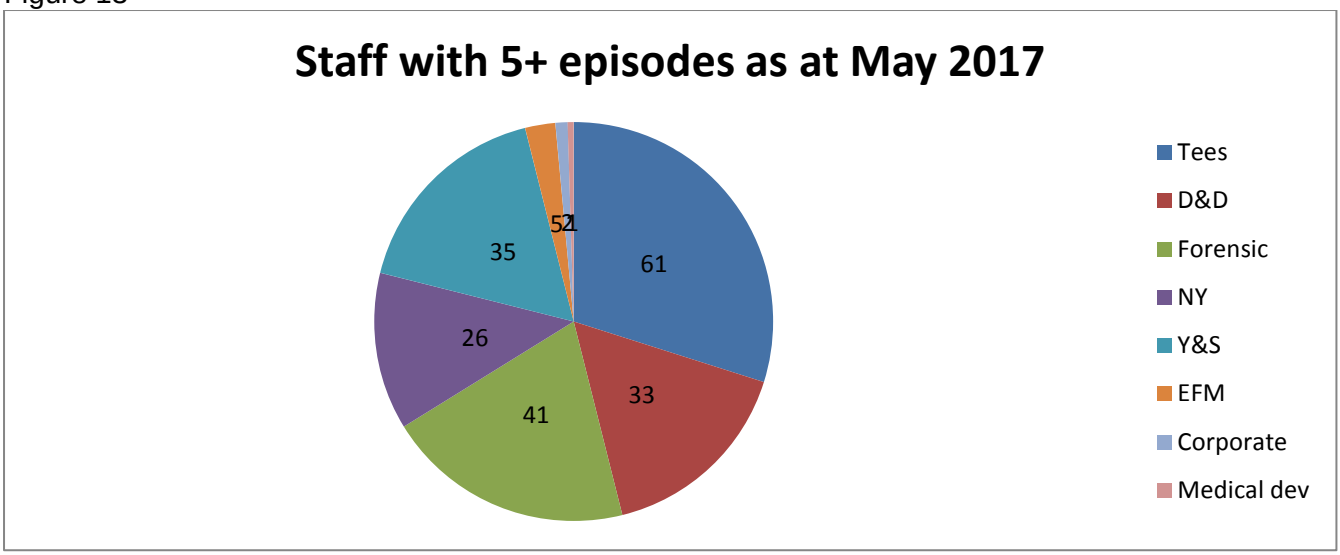
	2012-13	2013-14	2014-15	2015-16	2016-17
Anxiety/stress/depression/other psychiatric illnesses	331	327	336	326	406
Back and musculo skeletal	431	486	521	537	573
Cold, Cough, Flu - Influenza	1116	871	1046	1129	1300
Gastrointestinal problems	1534	1583	1378	1525	1798

4.3 It was recognised by EMT that over recent years short term sickness absence has fluctuated between 1.3 % - 1.7% with no significant sustained improvement. A number of initiatives have been undertaken over recent years in an attempt to support managers in managing short term sickness absence. These included sickness absence audits, monitoring of sickness absence for those with 3+ episodes, and training on the then revised sickness absence procedure.

4.4.1 More recently the HR department have focused on staff who have incurred 5 or more episodes in a 12 month rolling period. The figure amounts to in excess of 200 staff. Managers have been asked to provide an update on those staff along with an explanation as to how the member of staff is being managed in relation to their sickness absence. This gives managers the opportunity to gain advice as to where the staff member is at in relation to the procedure. Specific cases are discussed at case management and advice taken from occupational health where required. A recent proposal to provide regular updates to OMT and highlight made to areas of concern was approved.

A breakdown of the position as at May 2017 is attached at figure 13.

Figure 13



4.4.2 The following recommendations were approved by EMT to help the Trust better understand the issues which may be associated with short term absence.

- **More focussed analysis undertaken** - further deep dive analysis in to specific areas of concern eg teams where multiple staff have episodes of short term within the same team, in those teams have the managers attended the training provided, is short term absence a predictor of long term absence, how many staff experience short term and long term absence, are staff experiencing multiple episodes of stress related absences.
- **Monitoring of staff experiencing 5 or more episodes – to** continue to monitor 5+ episodes but look to design a robust process to more proactively manage those staff with higher levels of absence and ensure progression as appropriate. This will involve assessing the number of staff involved and capacity within the HR team.
- **Implement an audit programme –** whilst is it acknowledged the audit sample was small and in light of the overall poor assurance levels it is proposed to roll out an audit programme over the coming 12 months. Audit results will be discussed on a monthly basis with Directors of Operations and a quarterly summary provided to OMT. Action plans will be provided to the relevant manager and a review undertaken by the HR team 4 weeks following the audit to ensure any errors are rectified.
- **Training for managers in sickness absence management -** it is proposed to offer further training sessions to managers who are responsible for managing sickness absence. In a recent survey 70% of managers (who responded) stated that they would attend further training sessions with regard to sickness absence. More focus within the training will be given to scenario based examples to allow detailed discussion. For services where there is significant concern that sickness absence is not being managed in line with the procedure, targeted training will be provided.

Medical Workforce Report (2017/18 Quarter 1)

MEDICAL DIRECTORATE

This report provides information about the medical workforce during the first quarter (April, May and June 2017).

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

Summary

Recruitment continues to be challenging across all grades of medical staff. IR35 has made recruitment of agency staff even more difficult and increased costs further. All agency doctors in the Trust fall under the IR35 rules which make them liable to Schedule E taxation and National Insurance contributions. Many doctors seek to add these costs to their hourly rate which they are paid and because of the shortage of doctors nationally, it is a difficult marketplace.

The Faculty has appointed Dr Krishnan to the CESR Overseas Tutor post and plans are already underway to develop a development programme to coach a cohort of consultants working overseas. This will be reported further as we progress through the year.

There will be a continuation of the overseas recruitment initiative for trust doctors later this year and a panel will visit Budapest in October to interview candidates. The Trust has 11 doctors now working at this level and we continue to provide support to enable them to enter training in the North East and North Yorkshire.

A panel of doctors from the Trust will attend the BMJ recruitment exhibition in London this October. The Trust plans to advertise attendance at the event and offer opportunities for all grades of doctor to meet the team through informal drop in sessions or by appointment.

Section 1: Medical Staffing Profile

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

Table 1	D&D	Tees	N Yorks	Forensic	York and Selby	Overall Total
Permanent	94	83	54	30	44	305
Trust Locums	5	5	11		4	25
Agency Locums	4		5	2	5	16
Flex Retirement	4	1	3			8
Career Break		1				1
Honorary	2	1		1	1	5
Total	109	91	73	33	54	**360**

Table 1 shows a slight decrease in workforce since quarter 4 (366). The table shows that 85% of our workforce is permanent with 31% in the Durham & Darlington locality. This has not significantly differed since 2013. The highest level of non-permanent staff is in North Yorkshire at 26%. The number of agency doctors has decreased by 5. The introduction of IR35 has put further pressure on sourcing agency locums and this has resulted in higher hourly rates across the country. On a positive note, we have managed to persuade 3 agency staff to transfer to Trust locum posts (2 have already commenced and 1 is due to transfer next quarter). Currently there are 11 agency doctors over capped rates and 4 who receive additional help with travel and accommodation.

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

Consultant Psychiatrists

Table 2	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Permanent	60	33	29	13	12	7	155
Trust Locums	2		2				4
Agency Locums	5	2	2		1		10
Flex Retirement	4	2	1	1			8
Vacant not cov'd	9	2	3		1		15
Career Break							
Honorary	3	1			1		5
Total	83	40	37	14	15	7	**197**

Table 2 shows the number of consultants currently working within the Trust defined by specialty. Please note that out of the 10 agency doctors, 7 are covering vacant posts, 2 are covering sickness and 1 is providing backfill cover.

Of the AMH workforce, 28% are non-permanent and the Trust will need to monitor this to prevent further increase.

SAS Doctors

Table 3	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Permanent	16	5	11	1	2	2	37
Trust Locums	5		3				8
Agency Locums		2	3		1		6
Flex Retirement							
Vacant not cov'd			3			1	3
Career Break			1				1
Honorary							
Total	21	7	21	1	3	3	**55**

Table 3 shows the number of SAS grade doctors currently working within the Trust defined by specialty. Just under half (47%) of the MHSOP workforce are non-permanent, which has decreased slightly since last quarter.

Junior Doctors

Table 4	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Current	61	11	26	8	7		113
Vacancies not covered	12	6	3	1	2	1	25
Trust Locums	7	1	4				12
Agency Locums							
Total number of posts	80	18	33	9	9	1	**150**

Table 4 shows all Trust junior doctor training posts. The number of vacancies are those posts that remain unfilled after trust doctor and agency locums have been appointed. For information, Trust Doctors are used to fill vacant training posts and are not on a formal training programme. There are currently 37 vacancies that are either filled by locums or that remain empty. The trust has not used agency doctors to fill the vacancies over the last year. The foundation doctor changeover in April saw a number of vacant F1 posts, which will impact on services next year.

You will note that the Trust has 12 Trust doctor posts compared to 3 in 2013. This is quite unique and is a result of the Trust Doctor Programme that was developed to make the doctor better equipped to be succesful on their application for core training. The Trust went to Budapest in January and successfully appointed 7 Trust Doctors; three have since withdrawn. One doctor commenced in May with the other three doctors on course to start in August.

Table 5	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Foundation Yr 1	7		4				11
Foundation Yr 2	9		4		1		14
CT 1-3	21	7	9	6	4		47
ST 4-6	11	4	5	2	2		24
GP Registrars	13		4				17
Total	61	11	26	8	7		**113**

Table 5 shows the breakdown of junior doctors that are currently in post in the Trust. We continue to do all we can to support core trainees in passing their written and clinical papers. Please see the medical education report in section 8.

Section 2: Medical Staffing Monitoring Profile

This section provides analysis of gender, age and ethnicity of the medical staff workforce.

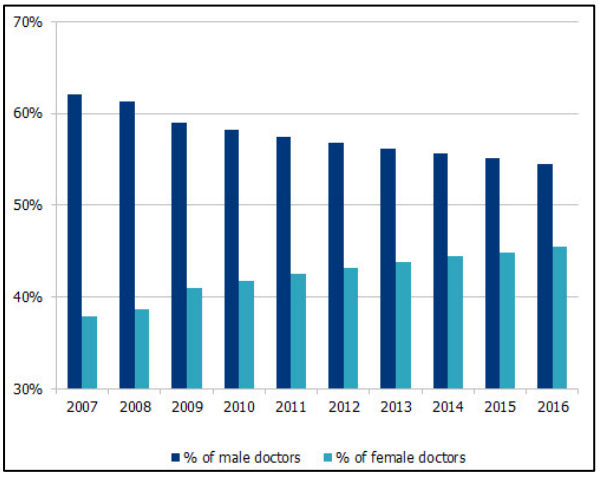
Consultants by Age & Gender

Table 1	D&D		Tees		NY		Forensic		York & Selby		Total	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	M	F
30 – 34	1	1		1		1		1	1		**2**	**4**
35 – 39	3	6	7	5	2	1	4	2	2	1	**18**	**15**
40 – 44	6	5	7	4	4	2	3	1	2	5	**22**	**17**
45 – 49	7	4	5	5	8	4	3	2	2	2	**25**	**17**
50 – 54	6	7	2	2	3	4	3	1	4	1	**18**	**15**
55 – 59	3	1		1	1				2		**6**	**2**
60 – 64	2	1	1		2				1		**6**	**1**
65 – 69	1				1						**2**	
70+									1		**1**	
Total	**29**	**25**	**22**	**18**	**21**	**12**	**13**	**7**	**15**	**9**	**100**	**71**

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 modal average age of the consultant workforce is between the 45-49 age group. This remains unchanged from last quarter. In contrast, Forensic Services remain relatively young with no-one over the age of 54. The male and female split in Durham and Darlington, Teesside and York and Selby are fairly equal which is not replicated in the other localities (there are twice as many males than females in Forensics and North Yorkshire). Overall, there is a 58/42% male/female split respectively (a 1% decrease/increase since 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 shortly exceed the number of males as shown in the picture below (GMC, 2017). 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	2	1		1		1				1			**2**	**4**
35 – 39	6	4	2	7	3	2	3		4	1		1	**18**	**15**
40 – 44	8	9	3	2	7	2	1	3	1		2	1	**22**	**17**
45 – 49	10	4	5	6	5	4	2	1	3			2	**25**	**17**
50 – 54	11	2	1	7	2	4	1	1	2	1	1		**18**	**15**
55 – 59	4	1				1	2						**6**	**2**
60 – 64	4	1	1		1								**6**	**1**
65 – 69	1		1										**2**	
70+	1												**1**	
Total	47	22	13	23	18	14	9	5	10	3	3	4	**100**	**71**

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. Forensic Services has a relatively young workforce with only 4 out of 20 doctors over the age of 50. Altogether, 30% of the consultant workforce is over the age of 50 with 15 males compared to 3 females. Something to note for the future is that 37% of the Adult Mental Health workforce is over the age of 50. In addition, the lack of a female workforce in Adult Mental Health and Forensic Mental Health remains evident from the data.

SAS Doctors by Age & Gender

Table 3	D&D		Tees		NY		Forensic		York & Selby		Total	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	**M**	**F**
30 – 34	1	1	1		1						**3**	**1**
35 – 39			2	2		1					**2**	**3**
40 – 44	3	2	2	1			1				**6**	**3**
45 – 49	1	2		2		1	1	2			**2**	**7**
50 – 54	1	3	3	3		1					**4**	**7**
55 – 59		2		1	1						**1**	**3**
60 – 64			2	2							**2**	**2**
65 – 69												
70+	1										**1**	
Total	**7**	**10**	**10**	**11**	**2**	**3**	**2**	**2**			**21**	**26**

Table 3 shows the number of male and female SAS doctors in various age brackets defined by locality. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. Please note there are no specialty doctors in York and Selby. In comparison to the consultant workforce, there is a 45/55% male/female split (2% increase/decrease since last quarter). The modal average workforce age remains between 50 and 54, with less than half (43%) being over the age of 50 (a 2% reduction from last quarter). It is also worth noting that half of our Teesside locality workforce is in the over 50 category (52%), though this has reduced since last quarter.

SAS Doctors by Age & Gender in Specialties

Table 4	AMH		CYPS		MHSOP		LD		Forensic MH		Forensic LD		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	**M**	**F**
30 – 34	3	1											**3**	**1**
35 – 39		1		1	2	1							**2**	**3**
40 – 44	3	1		2	2				1				**6**	**3**
45 – 49	1	2		1		2				1	1	1	**2**	**7**
50 – 54		4			4	3							**4**	**7**
55 – 59	1	1		1		1							**1**	**3**
60 – 64	2	1						1					**2**	**2**
65 – 69														
70+					1								**1**	
Total	**10**	**11**		**5**	**9**	**7**		**1**	**1**	**1**	**1**	**1**	**21**	**26**

Table 4 shows the number of male and female SAS doctors in various age brackets defined by specialty. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. It should be noted that male and female numbers are fairly even, except in CYPS where there are still no males. Of concern is that 56% of the MHSOP workforce are over the age of 50.

Ethnic Origin

Consultants Table 5	D&D		Tees		NY		Forensic		York & Selby		Total	
	M	F	M	F	M	F	M	F	M	F	**M**	**F**
White British	8	19	7	12	9	8	6	3	10	6	**40**	**48**
White Irish	1								1		**2**	
White European	3		2	1	3		1				**9**	**1**
White Other		1				1				1		**3**
Asian British – Indian	10	4	9	1	3	1	3	4	3		**28**	**10**
Asian British–Pakistani	1				1		1				**3**	
Asian British–Bangladesh					1						**1**	
Asian British–Other	1		1	1	1				1		**4**	**1**
Black British–African		1	2	2	2					1	**4**	**4**
Black British - Nigerian	1										**1**	
Black British–Other	1						1				**2**	
Mix White/Black–African	1										**1**	
Mixed – Other			1				1				**2**	
Chinese	2									1		**1**
Other				1	1	1					**3**	**2**
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' (88 White British and 83 non-White British).

When considering BAME consultants, 103 are European while 67 are from Asia, Africa or elsewhere (60/40% respectively) which remains the same as last quarter. Interestingly, the male/female split between Europe and BAME areas is quite distinct – 50% of the European workforce are male and 50% are female; in BAME areas, 73% of the workforce are male compared to 27% female. Also of note, is that the Durham & Darlington, Teesside and Forensic localities have fairly even numbers of European/other doctors (59/41%, 55/45% and 50/50% respectively), however, it's quite evident that North Yorkshire and York and Selby have a high population of European doctors (64/36% and 75/25% respectively).

SAS Doctors

Table 6

	D&D		Tees		NY		Forensic		Total	
	Male	Female	Male	Female	Male	Female	Male	Female	**M**	**F**
White British	1	4		5	1	2			**2**	**11**
White European		2								**2**
White Other	1			1	1			1	**2**	**2**
Asian British–Indian	1	2	5	3				1	**6**	**6**
Asian British–Pakistani	2		1	1			1		**4**	**1**
Asian British- Banglaesh	1								**1**	
Asian British–Other			1			2			**1**	**1**
Black British–African		1	2				1		**3**	**1**
Black British			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 28% of the SAS workforce are 'White British' (13 are White British and 34 (72%) are non-White British). When considering BAME SAS doctors, 19 are from Europe and 28 are from Asia and Africa or elsewhere (40/60% respectively). In contrast to consultants, the male/female split in BAME areas is (61/39% respectively) whereas the European workforce is highly biased towards females (21% males/79% females). In addition, Teesside has two thirds as many BAME doctors than European ones, whereas in North Yorkshire, 80% of SAS doctors are European.

Full Time / Part Time

Table 7

Consultant												
	D&D		**Tees**		**NY**		**Forensic**		**York & Selby**		**Total**	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	M	F
Full Time	26	11	21	11	14	6	10	6	9	6	**80**	**40**
Part Time	3	4	1	7	7	6	3	1	6	3	**20**	**31**
Specialty Doctors												
Full Time	7	6	10	4	2		2	1			**21**	**11**
Part Time		4		7		3		1				**15**

Table 7 shows the number of male and female consultants / SAS doctors who are currently working full or part time defined by locality. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. This shows that almost half (46%) of the career grade workforce are full time males with less than a quarter (23%) of females in full time positions. In addition, 9% of the workforce are part time males and 21% are female. Interestingly there are no male SAS doctors

working part time. Seventy percent of the consultant workforce are full time, whereas the gap is slightly less distinct within the SAS group (68% full time). Overall, 70% of the career grade workforce are full time. The number of part time workers has increased by 1% since last quarter and could continue to increase over the next few years due to the introduction of flexible working options open to all doctors.

Table 8

Consultant														
	AMH		**CYPS**		**MHSOP**		**LD**		**Forensic MH**		**Forensic LD**		**Total**	
	M	F	M	F	M	F	M	F	M	F	M	F	**M**	**F**
Full Time	39	14	9	8	17	10	5	2	7	3	3	3	**80**	**40**
Part Time	8	8	4	15	1	4	4	3	3			1	**20**	**31**
Specialty Doctors														
Full Time	10	5		3	9	2			1	1	1		**21**	**11**
Part Time		6		2		5		1				1		**15**

Table 8 shows the number of male and female consultants / SAS doctors who are currently working full or part time defined by specialty. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. Interestingly, the gap between full time males and females is quite evident in AMH, MHSOP and Forensic MH (54/21%, 54/25% and 53/27% male/female respectively).

Section 3: Vacancies

This section considers the number of current vacancies in the trust and the plans for recruitment, including whether a locum is covering at present.

Table 1	**D&D**	**Tees**	**NY**	**Forensic**	**York & Selby**	**Total**
Consultant	7	14	8	2	4	35
SAS	2	3	1	2	2	10

Table 1 above shows the current vacancies in each directorate. The number of consultant vacancies has increased by 11 since last quarter and the SAS vacancies have doubled.

Table 2	**AMH**	**CYPS**	**MHSOP**	**LD**	**FMH**	**FLD**	**Total**
Consultant	17	7	9		2		35
SAS	3		4	1	2		10

Table 2 above shows the current vacancies in each specialty. The number of AMH vacancies has more than doubled since last quarter.

Vacancy Breakdown

Table 3

Vacancies	**Locum in place**	**Times Advertised**	**Date of Advert**	**Date of Interview**	**Appt made**	**Start date**
Consultant in AMH (PICU) RPH	No	2	~~21/05/16~~ 01/04/17	~~11/07/16~~ 24/05/17	No	
Consultant in AMH (S'ton Inpatient / Crisis) RPH	No	1	19/05/17		No	
Consultant in AMH (S'ton Inpatient) RPH	No	0				
Consultant in AMH (M'bro Inpatients) RPH	Subs Cons	0				
Consultant in AMH (R&C Inpatients) RPH	Subs Cons	0				
Consultant in AMH (H'pool Inpatients) Sandwell Park	No	0				

Vacancies	Locum in place	Times Advertised	Date of Advert	Date of Interview	Appt made	Start date
Consultant in AMH (Rehab) RPH / Lustrum Vale	No	1 – internally	May 2017	02/06/17	Yes	08/09/17
Consultant in AMH (ADHD), Lancaster House	No	0				
Consultant in Liaison North Tees	No	2	~~14/05/16~~ 17/12/16	~~04/07/16~~ 15/02/17	No No	
Consultant in CYPS The Ridings, Redcar	No	3	~~07/05/16~~ ~~08/04/17~~ 24/06/17	~~29/06/16~~ ~~25/05/17~~	No	
Consultant in CYPS (6 PA) Dover House, Hartlepool	No	3	~~07/05/16~~ ~~08/04/17~~ 24/06/17	~~29/06/16~~ ~~25/05/17~~	No	
Consultant in MHSOP (8PA) (Liaison) North Tees/Hartlepool	No	0				
Consultant in MHSOP Lustrum Vale	Acting Cons	0				
Consultant in MHSOP (R&C), Redcar	Acting Cons	1	12/05/17			
Specialty Doctor in MHSOP (R&C), Redcar	No	1	April 2017	May 2017	Yes	19/06/17
Specialty Doctor in MHSOP (H'pool), Sandwell Park	No	1	April 2017	May 2017	Yes	Aug 2017
Specialty Doctor in Physical Health Learning Disabilities, Bankfields Court	Subs Sp Dr	1 – internally	05/0517	12/06/17	Yes	13/09/17
Consultant in AMH (Community Eating Disorders) Imperial House	No	1	04/06/16	01/08/16	No	
Consultant in AMH (Inpatient Eating Disorders) West Park	Honorary Cons	0				
Consultant in AMH (In-patient) LRH	Agency Cons	2	12/11/16	03/01/17	No	
Consultant in AMH (Inpatients) WPH	Trust Cons	1	12/11/16	03/01/17	No	
Consultant in AMH (Crisis/liaison) WPH	No	0				
Specialty Doctor in AMH (Inpatients) WPH	Trust Sp Doctor	0				
Specialty Doctor in AMH (Crisis) WPH	Trust Sp Doctor	0				
Consultant in MHSOP Auckland Park	Trust Cons	0				
Consultant in MHSOP (6PA) (Liaison) LRH	No	4	28/05/16	18/07/16	No	
Consultant in AMH Windsor House	Subs Cons	1	27/05/17	04/08/17		
Consultant in AMH (EIP/Female Inpatients) S'bro	Agency Cons	0				
Consultant in AMH (Male Inpatients) S'bro	Trust Cons	0				
Specialty Doctor in AMH Friarage Northallerton	Trust Doctor	2	30/07/16	~~12/09/16~~ 18/11/16	No	
Consultant in MHSOP Cross Lane Hospital / Malton	Trust Cons	2	05/12/15	~~30/07/15~~ 19/01/16	No	
Consultant in MHSOP (6PA) Whitby / Cross Lane Hospital	Acting Cons	0				
Consultant in MHSOP Clinical Academic, Scarborough	No	1	18/02/17		No	
Consultant in CYPS Scarborough	Agency Cons	1	Jan 2017	Feb 2017	No	

Vacancies	Locum in place	Times Advertised	Date of Advert	Date of Interview	Appt made	Start date
Consultant in CYPS (6PA) Scarborough	Trust Cons	0				
Consultant in Forensics (Offender Health) HMP Preston	No	1	27/05/17	05/07/17		
Consultant in Forensic (Forensic Mental Health), RPH	Subs Cons	1	27/05/17	05/07/17		
Specialty Doctor in Forensics (Forensic Mental Health), RPH	Agency	0				
Specialty Doctor in Forensic (Forensic Mental Health), RPH	Agency	2	23/07/16	~~13/09/16~~ 27/11/16	No	
Consultant in MHSOP York	Agency Cons	1	11/06/16	29/07/16	No	
Specialty Doctor in MHSOP (Liaison) York	No	1	24/06/17	07/08/17		
Specialty Doctor in MHSOP (Inpatients) York	Agency Doctor	0				
Consultant in CYPS York	Agency Cons	1	08/04/17		No	
Consultant in CYPS (7PA) York	Agency Sp Dr	1	08/04/17		No	
Consultant in CYPS (5PA) York	Agency Cons	1	08/04/17		No	

Table 3 shows the breakdown of each vacancy in the Trust and the number of times the post has been advertised (including any current adverts).

The table below shows the recruitment activity in this period (April to June 2017). Within this period 16 posts were advertised with 4 (25%) successfully recruited to (compared to 8 of 11 posts in the last quarter).

Table 4

Vacancies advertised	Times advertised	No of candidates applied	No of candidates shortlisted	Appointment made
Consultant in AMH (PICU) Roseberry Park	2	0	0	No
Consultant in AMH (Inpatients) Roseberry Park	1	0	0	No
Consultant in AMH (Rehab) Roseberry Park / Lustrum Vale	1	1	1	Yes
Consultant in CYPS (x2) Dover House/The Ridings	3	0	0	No
Consultant in MHSOP (R&C) Reed Marsh House	1	0	0	No
Specialty Doctor in MHSOP (x2) Sandwell Park/Reed Marsh House	1	2	2	Yes x2
Specialty Doctor in Physical Health LD, Bankfields Court	1	1	1	Yes
Consultant in AMH Windsor House	1	0	0	No
Consultant in Offender Health Roseberry Park / HMP Lancaster	1	0	0	No
Consultant in Forensic Mental Health Roseberry Park	1	0	0	No
Specialty Doctor in Liaison MHSOP York	1	0	0	No
Consultant in CYPS (x3) York	1	0	0	No

Section 4: Sickness

Doctors on Long Term Sick Leave by Locality

Figure 1

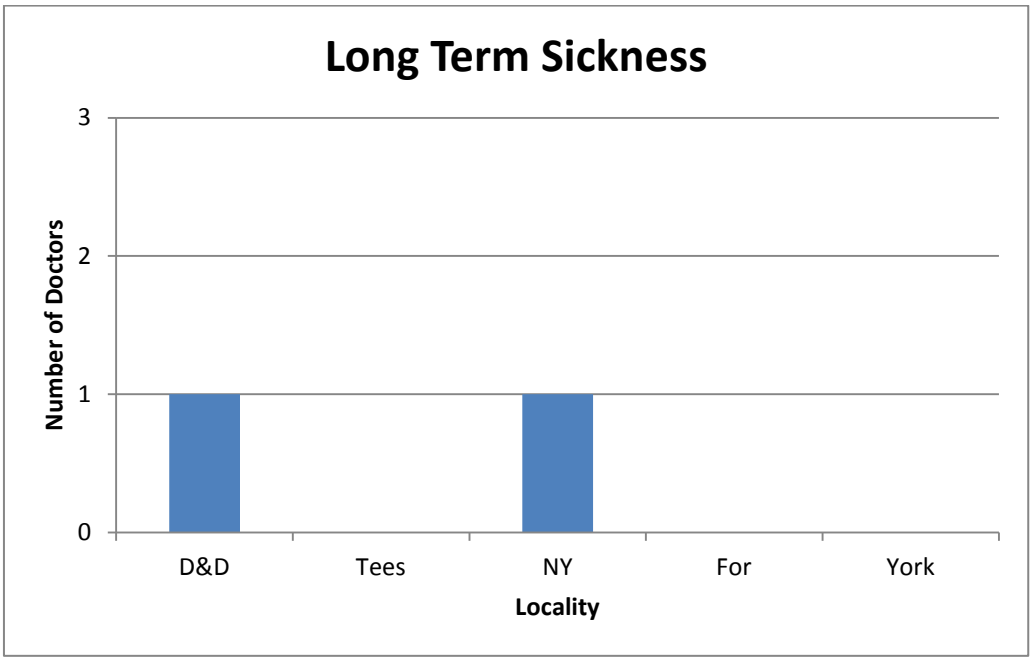


Figure 1 shows the number of doctors on long term sick on 30th June 2017. This has reduced considerably since last quarter. The two people on long term sick were also off sick last quarter. One of the long term sickness is due to depression and the other is due to a heart condition.

Reasons for Sickness Absence

Figure 2

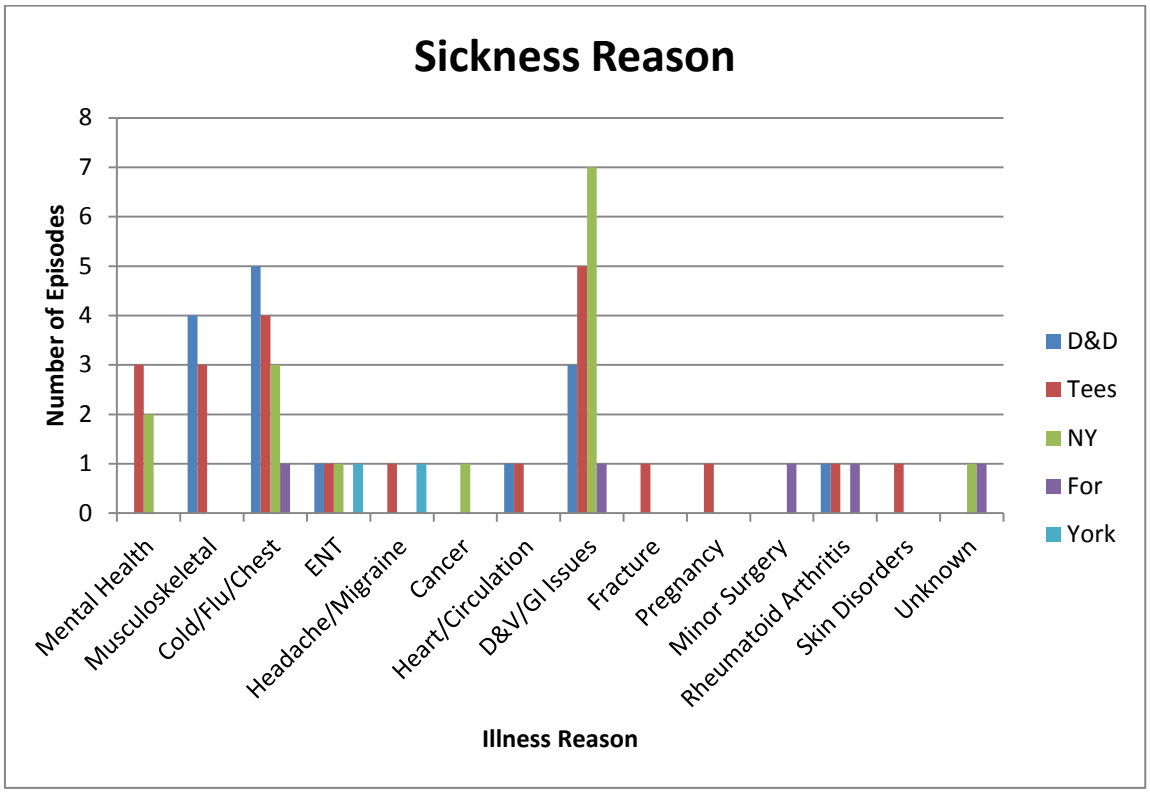


Figure 2 shows the reasons for sickness absence (including long term sickness) during the period April to June 2017. This includes all grades of doctor except agency locums. The number of cold, flu and chest problems has decreased dramatically from 32 to 13. The number of mental health issues has remained static at 5 episodes. The number of GI issues has also remained static at 16 episodes. Two of the Teesside mental health issues were down to bereavement stress. York has only had 2 episodes of sickness in the last 3 months.

Overall, 432 work days were lost due to sickness (357 days less than last quarter) out of which 169 days were for short term illnesses (a decrease of 225 from last quarter) and 263 were for long term illnesses (a decrease of 132). This is the first time in a year that sickness has reduced rather than steadily increasing.

Section 5: Appraisals and Revalidation

Consultants

Table 1	D&D	Tees	NY	For	Y&S	Total
Appraisals Due	7	7	4	2	5	25
Appraisals Actual	6	6	4	2	5	23

Table 1 shows the number of consultant appraisals that were due between 1st April and 30th June 2017 and how many were actually completed. The total number is broken down into locality.

Table 2	D&D	Tees	NY	For	Y&S	Total
Revalidation Due	0	0	0	0	0	0
Revalidation Actual	0	0	0	0	0	0

Table 2 shows the number of consultants who were due revalidation between 1st April and 30th June 2017 and those who were successfully revalidated. The numbers are broken down into locality.

SAS

Table 3	D&D	Tees	NY	For	Y&S	Total
Appraisals Due	0	1	2	0	0	3
Appraisals Actual	0	1	2	0	0	3

Table 3 shows the number of SAS doctor appraisals that were due between 1st April and 30th June 2017 and how many were actually completed. The total number is broken down into locality.

Table 4	D&D	Tees	NY	For	Y&S	Total
Revalidation Due	0	0	0	0	0	0
Revalidation Actual	0	0	0	0	0	0

Table 4 shows the number of SAS doctors who were due revalidation between 1st April and 30th June 2017 and those who were successfully revalidated. The numbers are broken down into locality.

Trust Doctor

Table 5	D&D	Tees	NY	For	Y&S	Total
Appraisals Due	0	0	1	0	1	2
Appraisals Actual	0	0	1	0	1	2

Table 3 shows the number of Trust doctor appraisals that were due between 1st April and 30th June 2017 and how many were actually completed. The total number is broken down into locality.

Table 6	D&D	Tees	NY	For	Y&S	Total
Revalidation Due	0	0	0	0	0	0
Revalidation Actual	0	0	0	0	0	0

Table 4 shows the number of Trust doctors who were due revalidation between 1st April and 30th June 2017 those who were successfully revalidated. The numbers are broken down into locality.

Section 6: Turnover

This section considers the number of doctors who have commenced in the Trust between 1st April and 30th June 2017. It also highlights the number of doctors leaving the Trust and their leaver destination.

New Starters vs Leavers by Locality

Table 1	D&D	Tees	NY	Forensic	York & Selby	Total
New Starters		5	1		1	7
Leavers		3	1	1		5

Table 1 highlights the number of new starters against the number of leavers. Again, this includes all types of staff except agency locums. The numbers of leavers remain static since last quarter; however, the number of new starters has decreased from 10 to 7.

New Starters vs Leavers by Specialty

Table 2	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
New Starters	4	2	1				7
Leavers	2	2				1	5

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	1	4	2
Leavers	3	1	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	York & Selby	Total
Flexible Retirement						
Retired (ill health)						
Fully Retired		3		1		4
Moved Abroad						
Needed to Relocate						
Left (alternative work)						
Other Local Trust						
Training Scheme						
End of Contract			1			1
Private Work						

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.

Leaver Destination by Specialty

Table 5	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Flexible Retirement							
Fully Retired (ill health)							
Fully Retired	1	2				1	4
Moved Abroad							
Needed to Relocate							
Left (alternative work)							
Joined Local Trust							
Joined Training Scheme							
End of Contract	1						1
Private Work							

Table 5 shows the destination of doctors after leaving the Trust, broken down by specialty. This includes all types of staff, eg permanent, locum, trust doctors – except agency locums.

Leaver Destination by Grade

Table 6	Consultants	SAS	Trust Doctors
Flexible Retirement			
Fully Retired (ill health)			
Fully Retired	3	1	
Moved Abroad			
Needed to Relocate			
Left (alternative work)			
Joined Local Trust			
Joined Training Scheme			
End of Contract			1
Private Work			

Table 6 shows the destination of doctors after leaving the Trust, broken down by grade. This includes all types of staff, eg permanent, locum, trust doctors – except agency locums.

Leavers over the last 2 years

The tables below show a breakdown of the leavers over the last 2 years (from 1st July 2015).

Table 7	D&D	Tees	NY	Forensic	York	Total
Flexible Retirement	1	2		1		4
Retired (ill health)	2		1			3
Retired Fully	2	4	1	2	1	10
Moved Abroad	6			2		8
Needed to Relocate		3		1		4
Joined Another Trust	2	2			1	5
Joined Private Organisation	1	1		1		3
Joined Training Scheme	3	4	4	1		12
End of Contract	3		5			8
Left (alternative work)	3	2	2			7

Table 7 shows that the majority of leavers came from the Durham & Darlington and Teesside localities. Interestingly, 19% of doctors left the Trust to join a training scheme, while those who either moved abroad, joined another Trust or left to find alternative work (eg with an agency or outside of medicine) make 31% of leavers. In addition, those who retired made up just over a quarter (27%) of the total leavers.

Table 8	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Flexible Retirement	1	1	1			1	4
Fully Retired (ill health)	2	1					3
Fully Retired	3	3	1	1	1	1	10
Moved Abroad	5			1	1	1	8
Needed to Relocate	3					1	4
Joined Another Trust	2	2	1				5
Joined Private Org	1	1			1		3
Joined Training Scheme	10	1			1		12
End of Contract	3	2	3				8
Left (alternative work)	1	2	4				7

Table 8 shows that 48% of leavers were from Adult Mental Health (possibly due to the fact that the majority of Trust doctors are placed within AMH services) while 20% were from Child and Young Person's Services.

Table 9	Consultants	SAS	Trust Doctors
Flexible Retirement	4		
Fully Retired (ill health)	1	2	
Fully Retired	8	2	
Moved Abroad	7	1	
Needed to Relocate	2	1	1
Joined Another Trust	4		1
Joined Private Org	3		
Joined Training Scheme		6	6

Table 9	Consultants	SAS	Trust Doctors
End of Contract	3	2	3
Left (alternative work)	5	2	

Table 9 shows the grade of leavers. Fifty eight per cent of leavers were consultants.

Section 7: Mind the Gap Payments

This section includes the number of extra PA payments that are being made within 'Mind the Gap', eg for providing cover during sickness or vacancies, over the last 3 months. It is broken down into locality and specialty.

Table 1	AMH	CYPS	MHOSP	LD	FMH	FLD	Total
D&D	17.5						17.5
Teesside	19	23.26	7.5	4			53.76
NY	1.6	2	3.5	1			8.1
Forensic					5	6	11
York	8	2					10
Total	46.1	27.26	11	5	5	6	**100.36**

Table 1 shows the number of additional PAs under Mind the Gap. This shows that the number of additional PAs has increased considerably since last quarter (73.68). The most dramatic increases are in Adult Mental Health and CYPS in Teesside. Teesside makes up 54% of the total additional payments.

References

GMC, (2017), *List of Registered Medical Practitioners – Statistics,* Available at http://www.gmc-uk.org/doctors/register/search_stats.asp. Accessed 15th June 2017.

Section 8 – Medical Education Overview

Medical Education Events

Annual Clinical Audit (May 2017): The event provided the trainee in each locality with the opportunity to present their audit (which had won them their locality prize) to a wider audience showcasing the best for each locality. However the low rate of audience participation and trainee supervisor's attendance was disappointing and we hope to improve upon this in future years to continue the success of this event.

Grand Round Teaching (Teesside: May 2017): This year's event was led by Dr Cameron Martin with the theme of "Desperate Measures and Resistant Cases". Held at the Middlesbrough Football Club, the teaching was well attended with positive feedback received. The second round is scheduled to take place in October at the York locality being led by Dr Juliette Kennedy.

Annual Medical Education Conference (June 2017): The conference was hosted at Wynyard Hall with a full programme of medical education themes under the heading "Primary Care/Mental Health Alliance – Education is all a matter of building bridges" (Ralph Ellison) with associated workshops and the exhibition of poster presentations arranged by Dr Lisa Kwentoh and Dr Aniruddha Rajkonwar. The conference was well attended with extremely positive feedback received from the delegates.

SAS Away Days (Annual): The TEWV SAS programme continue to be delivered bi-monthly throughout the year .The newly appointed Associate SAS tutors hold responsibility for organising the annual programme and identifying key topics and sourcing appropriate speakers to facilitate sessions at the away days.

Newcastle Jobs Fair (June 2017): Attended at St James Park in Newcastle and represented by members of the TEWV Medical Education team, Emma Tootle and Val Holmes together with Dr Mary Parker, Dr Kim Barkas and Dr Aniruddha Rajkonwar. Educational and clinical staff had the opportunity to speak with the fifth year medical students attending to give them a flavour of working at TEWV to entice them down the career path of Psychiatry!

Quality Visits 2017

In the first six months of the year the TEWV Medical Education Faculty have hosted the following annual quality visits:

- **January:** Joint FP/GP Annual Visit
- **February:** HYMS Quality Monitoring & GP Annual Visit
- **June:** HENE ADQM Annual Visit

Overall TEWV have received excellent or outstanding feedback across all visits, with some minor actions arising from each of the programmes for address. These have been added to the relevant QiP for each programme and the areas of good practice have been included in the SAR (Self-Assessment Report) for submission to HENE in October 2017

GMC Survey 2017: We are currently awaiting the results from the GMC survey which includes feedback from both trainees and trainers and we anticipate the results will be made available in July.

As in previous years all of the management and organisation of events has been successfully co-ordinated by Val Holmes – Quality and Events Officer

Staff Friends and Family Test - Quarter 1 2017

RAG Table for Trust wide

	Q4 2015 n2694	Q1 2016 n3011	Q2 2016 n2861	Q4 2016 n2914	Q1 2017 n2721
How likely are you to recommend this organisation to friends and family if they needed care or treatment	82	82	81	82	84
How likely are you to recommend this organisation to friends and family as a place to work	72	72	72	72	72
*The care of patients/service users or supporting clinical services is the top priority for my team	80	81	88	89	91
I am able to make suggestions to improve the work of my team/department	80	78	82	82	82
*I believe that it is worth my while making suggestions			76	74	76
*There are opportunities for me to show initiative in my role	76	74	81	81	81
*Overall my role gives me job satisfaction			78	79	79
*I believe people within my team treat me with dignity and respect			87	85	87
*I am able to access job relevant non-mandatory training and/or continuing professional development opportunities			81	80	81
*Would you be interested in any physical activities/groups that the Trust could facilitate for you					50
*TEWV is supportive of, and values staff members that have lived experience of mental distress					66

Excellent: 80%+	Good: 65% - 79%	Fair: 50% - 64%	Poor: 40% - 49%	Very poor: under 40%

New or amended questions

Free Text Comments

How likely are you to recommend this organisation to friends and family if they needed care or treatment?

Extremely likely

I know how hard the staff within our trust work and I would be more than happy to encourage my friends or family to engage in support.

Staff are professional and caring.

Very high quality of care. High staff morale and caring attitude.

I think that in general the Trust provides good quality and compassionate services.

If they are living within the catchment area of the Trust (which is huge), then they would have to access only mental health care provider in that region! Some services and staff are excellent; some not so great, from my experience.

My answers may vary according to whether I am referring to the consortium which I work into or my employer TEWV.

It is one of the best Trusts who have excellent and well trained staff.

TEWV delivers high quality care and involves service users and their families in decision making.

I have confidence in all clinicians that work in the trust.

Unfortunately having personal experience with a family member needing to use the adult crisis team 2 years ago it was second to none the care we got.

Based on my experiences of LD community teams.

I think our services are very person centred.

The staff I work alongside are kind and considerate and very hard working to make sure the service users get the care they need.

I have a family member who has been admitted to the TEWV trust in the last eight months, and I am so pleased what has been done for them and what they have done for themselves.

Just recently I have received information that the trust has been awarded a Good rating for care quality, this and other attributes makes me feel that the above choice I have made is correct.

In my experience, patients have been happy with the service provided.

Having been on the professional side for more than 30 years, I now find myself being involved personally, as my husband has been diagnosed with vascular dementia and we are utilising the services offered at TEWV.

There is no choice - it is the only mental health Trust in this area.

I believe we have always delivered outstanding care with the trust being very forward thinking and patient focussed.

I feel our staff are truly committed to providing excellent services to patients and their families and carers, the staff have a great deal of pride in their work.

Survey fatigue on having to do this over and over is reducing my 'satisfaction' greatly.

I believe we provide a good service.

Quality care and patient safety are high priority in TEWV.

Staff always have patients care high on their priority, they always do their best and go above and beyond.

The care and consideration given to patients in my experience is exemplary.

Only NHS mental health secondary service in area.

Very caring and professional team who genuinely want to make things better for patients and families.

Excellent service, good communication diverse amount of services available.

Offer fantastic services and all the staff are supportive.

I feel TEWV would be able to offer appropriate care and treatment to a very high standard if needed.

Despite the increasingly robotic culture of the NHS, employees at TEWV are able decent people who do their best.

Very friendly, caring and helpful.

TEWV's five values of: Commitment to quality, Respect, Involvement, Wellbeing and Teamwork are the ethos of the way support is given and this is for the patients experience to be the best possible with a person centred approach, which I would wish for.

Extremely caring staff. I already have family who access the services and are very satisfied with the care they receive. Thank you.

Working in MHSOP excellent care for the age group and early detection and treatment I would and have ensured family members have been referred and assessed.

I believe my colleagues (nurses) go above and beyond for the care of patients and would highly recommend my friends/family.

A family member has received treatment and this was a very positive experience for him and the rest of the family.

I have had a relative stay in the hospital and she has praised the care she was given.

Very caring staff.

Caring staff.

I believe that the systems that are in place across the organisation assist staff to provide a very high standard of care. On the whole the staff delivering the care are compassionate and caring.

Staff are very friendly and helpful and give a high level of care.

Having undergone a serious illness in 2015, I know first-hand how brilliant the treatment and how professional the nursing staff are.

Likely

Organisational standards. In addition, I know that the people I work with are compassionate and service user focused.

Not actually any choice is there.

TEWV has a virtual monopoly over a large area. It's hard to comment on TEWV in its entirety.

The staff on the wards I work on are extremely caring and want what is best for the clients. They remain dedicated even in challenging situations.

It’s the biggest provider of mental healthcare in the area so seems the obvious choice.

The frontline staff are excellent and very approachable, however the targets and short-staffing probably makes waiting procedures lengthy and frustrating for clients.

If my family or friend needed an adult inpatient admission I would not recommend TEWV. At times I observe that clearing beds is the priority rather than patient care. I do however feel that there is reasonable access to appropriate skills within the MDT.

I believe TEWV staff strive to give their best irrespective of conditions in the organisation. For example low staffing levels.

There is little alternative in this area.

Friendly, polite, efficient and confident staff.

If the waiting times were shorter I would have said extremely likely.

Would indicate the wait times and impact on the service as more demand than capacity at times.

I work in a good team and we try to ensure patients and families are seen in a timely manner and receive good interventions.

TEWV provides good service with caring and experienced staff but waiting times can be too long for them to get the right treatment.

To the team I'm involved in. I would not recommend other parts of the trust.

There aren't really any viable alternatives in the region.

Likely because there is really no alternative. My family have had very mixed experiences of AMH services - particularly frustration with frequently cancelled and rearranged appointments and long delays getting physical health checks done.

View may differ depending on which service.

There are no other Mental Health Trusts in this area so family or friends would have to come here if they needed treatment.

Unfortunately over the last ten years TEWV has become a business and is in my opinion too big an organisation. However I have worked for other trusts and care provision is better than in those.

From personal experience I am aware that waiting times are lengthy for people needing community treatments such as CBT but once you are in treatment the quality is good and

has helped me.

Some care settings are fantastic, others not so much, so on this basis I have chosen likely.

On the whole I think our staff want to deliver the best service they can. However, I also think there are still areas where our service users don't receive the best care they could.

TEWV is the only mental health service provider in North Yorkshire. There is no choice.

Except if the service was in the Durham and Darlington locality.

I see some really good clinical practice in my role but I have also had a family member who has had poor care so I am unsure how to answer but most of the work I have seen from staff is positive.

It is the most local service provider and have direct experience of working across many of the services provided.

Positive modules like Safe-wards and the triangle of care all help towards positive treatment.

Standard of care is generally good, although family experience of one particular service was poor.

Using my own experience of working with such a dedicated team, who are committed and work so very hard with the patient's we care for. I would like to think that if I needed help they would help me achieve my goals, the experience is so invaluable.

TEWV employ highly skilled practitioners however I am likely to inform friends / family as to the limitations placed on practitioners due to current service demands. If needs were long term or someone required regular sessions I am unlikely to recommend.

Waiting times.

Capacity for clinicians to deliver the comprehensive intervention and access to specialist intervention. Staff are dedicated, compassionate and conscientious.

It would depend on the reasons for referral, and what part of the service they would be accessing.

Feel TEWV delivers high level of care.

I do think the nurses and support workers are some of the best.

I have witnessed excellent treatment from professionals who go over and above the call of duty to provide the best service possible to patients and carers. However it saddens me to say that I have also been witness to people being judged before they have.

Although I would recommend TEWV for care and treatment, I believe that there a lot of inconsistencies in the delivery of care and treatment and the resources available in different localities.

If they were at a stage needed treatment or care there would be 'no other choice available' in the area so not very relevant wording of the question.

There are no other choices for mental health care other than private.

The staff in my area, particularly the nurses and health care assistants. They work hard and are committed to providing a high level of care for patients.

Staff are caring, friendly and knowledgeable and the facilities are great.

It's the only provider in the area.

It would be extremely likely if not for the blanket ban on inpatient smoking policy. I believe - in terms of mental health - smoking cessation is not a priority. I have researched evidence to prove this too. Smoking cessation should be offered to our inpatients.

I would have given extremely but have encountered calls from people unhappy that they are received letters with no contact details on regularly and chasing up contact as they haven't heard back on matters.

There are no other options available within the locality for mental health care.

High quality services.

It would depend which part of the trust. I would not allow any of my family to be admitted to West Park as very poor.

Particularly friends.

Team I work in are very good and provide good level of care. Can't really comment on other teams.

Good employer.

We can do better to ensure all areas provide a similar degree of high care and that care is not too variable as compared to one area to another. I remain optimistic that with PPCS and PIPA implementation across the Trust this will improve in the coming year.

I think it would depend on what services they require and which locality they live in.

Depending on area and involvement.

It depends on the individual service as experience has shown some are much better than others, and some are very poor.

They don't really have a choice if they are in our geographical catchment area! We seem to have some excellent services and others that do not seem quite so good. I suspect this is the same in any large organisation.

TEWV cover a large geographical area so identifying another NHS mental health service would involve traveling some distance.

There are no other services available, so there would be no choice in the matter.

It is the only real provider in the area anyway.

Dependant on which service.

Recovery focused approach.

I feel that care pathways are being improved, although demand on services remains too high.

Staff are generally highly motivated and diligent. Evidence-based care is provided.

Being the provider of appropriate care for the area they wouldn't have much choice.

Some services are better than others.

However it would depend on which service they need, I feel some services are far too stretched.

Developing, responsive services and coherent organisational structure.

There are no other alternatives, so I would have to refer to the service for mental health or learning disability.

This would all depend on which ward they were likely to be placed though.

Passionate staff that really do seem to care about their patients.

Not many alternative options due to the size and spread of the organisation.

All efforts made by staff are welcomed, however, little recognition is given.

Neither likely nor unlikely

Have just started with this Trust and as yet do not know the full scope of the services available.

Knowing my team I would without doubt recommend families and young people , they would get a good service but this is not consistent through the trust. I would not recommend some parts of the service.

I am aware that the pressures on clinical staff and staff shortages are impacting on the quality of care we can provide. I would be reluctant to recommend a service and raise expectations.

Depends which service they were accessing.

I would be concerned that my family member would be given medication as a first option rather than having more psychologically informed care. Services are under so much pressure at the moment that care is less than optimal.

Senior Management veiled threats, bullying and not knowing if you where you might be working from one shift to the next due to shortages and high levels of sickness and low staff morale.

As TEWV is the NHS funded organisation for this area I don't think it’s about recommending as there is no alternative choice unless you have the funds to pay for private care. Hypothetically is there was additional choice I would most likely not recommend .

Depends what for. Too general a question.

Not enough time spent interacting with patients due to demands of non-practical care.

Patchy services with variable levels of care and limited understanding of physical health needs in ward environments.

It would depend on where about they needed to go...if they needed in patient care I would hesitate due to working in inpatients myself. Also....I would feel happier if I was sure that their personnel information was well looked after.

Staff shortages make it hard to give the care needed.

Good with therapy work but leaves and visits get cancelled all the time due to staffing.

Resources are stretched, particularly in general adult services. Patients on general adult wards are all too often discharged before they are well enough to go. This is often the result of pressure on beds. On the positive side most staff try their best.

There are some amazing staff in TEWV. But I feel that client's needs often come second to the service, commissioning and target needs.

Not had any experience of treatment within Trust.

I have no knowledge of treatment provided as I work in an administration office.

The vast majority of my friends and family do not live within the Trust area. However, as the moment I am concerned that the Trust puts what is better for financial purposes ahead of what is best for an individual patient.

Too much variation within the trust as to what is available depending on where you live or which GP you have.

I am aware that current CMHT workers have large caseloads and over the past few months there has been a high number of SUI's, the demands of the job and excessive Paris documentation does not offer time for staff to spend time with patients.

I think that the staff whom I meet through TEWV are very patient centred and have good patient care at the heart of what they do.

Only choice in this area.

The staff are working on minimal numbers and can only give care they are trained to do and not the little extras such as spending time to reassure distress patients and their relatives/carers.

I would recommend local North Yorkshire services. However, my experiences of other staff in different locations in the trust means that I would not recommend these teams to anyone needing care.

Some parts of the service are better than others- there are variations in terms of what treatment you may get, depending how well a team/service/area is resourced- e.g. there are very limited OT's, physios and psychology posts/hours in the area I work.

There is no other mental health provision in the area.

There are few options for them to go elsewhere so no real choice.

This is hard to generalise the whole trust on just my experience of where I work. Where I work have internal waiting list, low staff level and I know families become frustrated by this, which would make me not want to access this.

Where I work it is more about figures and breaches than patient care, I feel.

The level of complex care to client ratios are skewed and unsafe leading to inability to provide the care we should be effectively.

Patients don't have a choice in provider!

Services are lacking staff due to not being replaced when leaving/retiring. Staff are expected to carry out more roles and responsibilities with less recourses. Staff are stressed.

With the current cutbacks in mental health I feel unable to recommend the service. The needs of the service users do not seem to be taken into account, only reducing costs and saving money.

The extensive demands and resulting stress placed on workers I have seen thus far in this post seem to adversely impact the care that can be offered. However, this may be localised to the area as the Trust itself and the broader organisation appear to off-set this.

Hard to comment as I only work within one team within TEWV, where the wait times for one to one therapy are significantly long. I could not comment on the whole of TEWV services, as I've not worked within different teams.

Secondary care mental health services are geographically provided. This is therefore a meaningless question because there is no alternative choice.

TEWV as a whole is very well run but there are significant difficulties in the locality where I work.

Depends on the service. I would not for instance recommend the inpatient service for older people in this area.

Lack of timely treatment and poor discharge commissioning.

Unlikely

Normally my experiences are very positive however recently starting work my care has become very ad hoc and unsupportive.

TEWV looks good on the surface but decisions are made remotely and with little respect or regard for staff who work at the coal face. So many demands are made on staff to comply with procedures that make TEWV look good on the surface.

My main experience is within CAMHS and I would be concerned that they would not get the level of care required due to the pressures on the service.

Sadly people don't have a choice for Mental Health Care. I don't think TEWV offer a good service to patients.

Pressure on staff to see more people in relation to meeting contact targets, and spend ages electronic form filling, reduces time available for really good formulation based reflective care, where a real and sustained therapeutic relationship can occur.

The waiting lists are too long because there isn't enough staff. If they needed help I'd tell them they'd have to pay for it elsewhere or not get any help for a very long time.

Staff are overstretched, are highly stressed and can’t give their best for trying to get through the day how can they be helpful.

Understaffing can affect care giving.

Strains on resources are massive and very often the basics are the things that suffer such as patient care and compassion.

Treatment isn't holistic, services seem to be behind the times and some staff's attitudes towards patients are terrible.

My daughter has waited 10 months for an autism assessment.

I have serious concern over the amount of layers involved in people accessing care. Teams and process seems to be seriously over engineered.

As the company is based in Tees and I live in North West.

It really depends on the locality and service. There are specific services that I have a working familiarity with that I would avoid at all costs for delivering inconsistent and poor care at best.

Although I think all staff I am aware of do a great job, the service is underfunded and understaffed and I understand that further cuts are on the horizon. I cannot see how I could recommend knowing how long someone would potentially have to wait.

Lack of community resources to support the care and treatment provided by TEWV.

Dependant often on individual clinicians.

Service provision unavailable or withdrawn with little or no follow up.

I gave more detailed feedback for this answer the last quarter - based on a family member being within in-patient services for a lengthy period of time and having many negative issues and experiences.

Working for the trust I would wish to maintain my privacy and therefore not likely to recommend for my family but would for friends.

Long wait for assessments and follow-up, staff overwhelmed so don't always communicate well and not always adequately trained to give treatment.

Not enough staff to run a shift safely so this effects the care of the patients.

Experience of TEWV systems too process driven. Stifles creativity.

Not enough staff to help patients get the one to one time that would help them recover quicker.

Too much money spent on managers and too little for clinical staff.

Long waiting lists, huge caseloads, burnt out community staff - young people do not get an adequate service (this relates to CAMHS services).

Extremely unlikely

There's quite a bullying culture at the moment.

They don't live in this catchment.

Services are a joke. The current approach is so long as exceeds waiting time then everything is fine. Lip service is paid to evidence based practice.

I am stretched to capacity, all CAMHS training is on hold and I know my team are going to change massively because of temporary contracts expiring and staff burning out.

Care is more about targets than care. Registered staff are bogged down in documentation making it difficult to spend time with patients.

People are not given a choice where they receive their care. If they live within TEWV's operating area they will receive care from us. If not they won't.

Lack of resources; no priority for care of individual.

Due to national and trust policy little regard is given to the needs of patients who are pigeon holed onto care pathways that they do not fit, we deal with people not cars, the Toyota model work for car production where there are static reference points.

Trust is too big that services are spread too thinly. Even simple things like staffing are not being looked at.

Long waiting times for mental health support. Poor quality service at times.

Don't know

There isn't anywhere else in the local area to recommend for treatment and care.

Lack of staff to provide good quality care and assessment.

If the patient has no choice in who provides the care then what is the point in asking the question. Unless you think this is a good way of allowing private health providers to gain access to NHS under the guise of patient choice.

All of my family live in the South, I think it would be inconvenient for them to attend here. I also can't make comments about other services, I can only make comments about local services, those who live locally, what other options do they have?

I would like to think that my family and friends could avoid needing support from MH services.

Had bad experiences working for the trust. Some of which staff members have bullied people and this has been at a senior level.

How likely are you to recommend this organisation to friends and family as a place to work?

Extremely likely

I feel supported in my development and in being helped to achieve a good work life balance.

Excellent place to work with very supportive management.

Great opportunities for training and development.

Because it is a good place to work, the organisation seems to look after its staff.

I cannot thank my employers enough they have supported me so much that I often feel guilty that I can't always give back 100 per cent.

The best trust I have ever worked in. Very supportive of staff, very efficient and competently run and managed.

Very supportive place to work excellent occupational health service. Good HR.

There are some things that could be done better but overall I think TEWV is a very good place to work.

Friendly and well organised environment. Good opportunity for learning.

I feel TEWV supports staff, and gives good opportunity to further skills.

Fantastic trust to work for.

Well manage and good support for staff.

Well supported and flexible working.

I have had some personal problems and the Trust are proactive in supporting their staff to remain at work offering many courses to support stress and mental health issues.

Our HR policies are family friendly and offer great support for good mental health e.g. mindfulness, bereavement leave, retreat and so on.

I love the team I work with and our Team Manager is excellent, all the staff are so supportive of each other.

Because of how working for the trust myself has helped me look at things more differently.

MHSOP is a very supportive team and staff are valued.

All my colleagues are friendly and helpful.

Although I have not worked for the Trust for long, I feel that TEWV is a supportive organisation to work for. In my experience the staff are valued and there are many initiatives to help with staff wellbeing, such as the retreat, exercise programmes, mindfulness session and other free courses.

Good health and wellbeing schemes for staff.

I have worked for the trust for over 24 years and many of my family work within the trust already. I would recommend the trust to any friends or family looking for a good employer and good job satisfaction.

A good company which has enabled to further enhance our knowledge on mental health by encouraging us to study further.

I really enjoy working for TEWV, I feel they are committed to supporting patients and staff and make the staff feel valued, there are always opportunities for staff to develop.

I feel TEWV is a very supportive employer and that senior staff appreciate that staff work hard in their roles and are committed to improving services.

As an employer TEWV provide good training and support to their staff.

Great emphasis on staff morale.

Excellent place to work, excellent management and facilities available. As a healthcare professional, I have the freedom to devote my work to the care of the patient. The hospitals are treated as hospitals. Staff are valued. Well done guys, I absolutely love been a part of TEWVs (thank you).

I have encountered fantastic support from managers and work colleagues.

Feel very supported by TEWV, good access to support.

TEWV has demonstrated its commitment on quality improvement and staff wellbeing and health.

The team is very nurturing and supportive. There is a great deal of opportunity to learn and progress.

Good opportunities to develop, pay scale and job satisfaction.

I work with an amazing team who are all approachable and friendly and supportive. Management are always available for support and advice which is very reassuring.

I have always enjoyed working for TEWV and for my team.

It's an organization by and large, staffed by able and decent people.

Lovely team to work in. Staff friendly.

I feel as though my profession is becoming more widely acknowledged with the physical healthcare agenda which makes me feel like the job we do is worthwhile and appreciated. The Trust is now fully committed to managing obesity.

Both my mother, father and sister work for TEWV, my mother has just retired and I love my job and have worked for the trust for 19 years mother and father both 30ish years, this alone says a lot.

I transferred from Leeds, and have been impressed with TEWV as an employer; lots of training available, equipment provided and investment in new buildings.

Good team spirit.

There are excellent opportunities for staff development and progression. The organisation invests a lot of time and effort into developing staff.

I find working for TEWV supportive, with good information and networks.

There are excellent opportunities to develop, and a true commitment to staff experience.

Excellent trust to work for, with great training and progression opportunities. There is also a lot of staff support in all of the teams I have experienced.

I have worked with the mental health team for over 16 years and still look forward to coming to work every day. I have always felt well supported by colleagues and management alike.

Likely

Staff support services.

Although personally I have always been happy working within this trust I feel that we need to do more work to nurture and support our new and junior staff -- I am increasingly worried about the level of violence that staff are subject to both physical and verbal.

Low pay, but otherwise 'extremely likely'.

It’s a good place to work especially if you have an interest in mental health.

I feel TEWV is a good organisation to work for - I have not put extremely likely because of the challenges faced by clinical staff in delivering good care.

Compared to other Trusts, this trust is much more supportive and systematic.

Good team spirit, evidence based training, supervision and staff support.

High caseloads make me hesitant but compared to other trusts in the region, it is one of the best.

It would depend on the service they are thinking of working in.

Good opportunities for training and career development, particularly if you are young.

I think the Trust overall is an excellent place to work. It still struggles to tackle issues in some areas at some level.

I feel I am well looked after Progestin routes could be clearer.

I have worked for the Trust for 16 years and wouldn't chose to leave for another NHS/public sector organisation.

Good place to work, however given minimal pay rises in the NHS and restrictions on moving up scales would ensure this is considered.

TEWV needs professional staff who can challenge the current bureaucratic way in which the Trust is run. The Board of Directors needs to be clinical staff including consultants and nurses, carers and ex-service user to ensure that the delivery of services is of a measurable

quality to encourage recovery results of patients.

Except if the post was in Durham or Darlington.

Really depends in which Directorate/Team - some good some not so good.

Very supportive.

Staff wellbeing - more to build and value them in the team.

Very demanding role with challenges in delivering high quality productive services in NY with limited resources.

The NHS on the whole is an excellent employer. Within TEWV I again would say it depends on the area you work and whether you curry favour with your manager. I have seen colleagues be given more and more responsibilities and be chastised for documentation not been 100% even when the reason it has been less than perfect is because they were providing a service to actual people. I fully understand the need for accurate and up to date documentation, both for the patient and their continuity of care and for the organisation, but when people are getting emails from their manager saying this is how much you have cost the trust today, when they have just worked 2 hours over (which occurs regularly and for free) I think borders on bullying. Organisational change is never easy, and changing cultures is definitely an uphill struggle but support and consideration is usually a lot more effective than naming and shaming in my experience.

I would recommend people to work for TEWV however I would highlight the varying opportunities to develop their career over the locality. I would highlight to them how nursing has changed from delivering care to services users to achieving expected targets that at times feel unachievable because of staffing levels, high caseloads. Personally I love the area I work in but this I feel is because I work in a close supportive team.

I think the trust does offer some good opportunities (Training and development) but staff are feeling pressured and undervalued at this time due to the messages coming from things like PPCS - no matter how positive people are some people will see it as a restrictive practice that kerbs innovation and is looking to cutting posts.

Feel supported by immediate managers, less so by senior managers.

Again I would have given extremely likely but I think we have work to do regarding staffing.

Any work place is usually dependent on the management for its success, therefore with good managers work can be truly fulfilling, by the same token, should the reverse be the case staff are less enthusiastic about going to work.

I've stayed for 20 years and I feel things have improved in terms of vision and leadership.

Again I would not advise them to work in the Durham/Darlington area.

Varies between areas and teams but overall a sound employer with potential for personal development.

I think they are a good employer as they have allowed me to be very flexible with my hours due to my caring needs. I do think they overwork us though and don't always recognise us for the commitment we show.

I would not recommend certain parts of the trust to work in to my family and friends.

Similar to above - it depends on which division and which locality.

I usually would choose extremely likely for this option and I still feel that the trust is a caring and compassionate trust and would recommend that people work for us, but at the same time I feel that the excessive funding cuts from the government resulting in schemes like CRES and PPCS put pressures and strains on workers in an already stressful job. Every person I work with puts their heart and soul into helping the people they work with, and I feel this is undermined when diaries are scrutinised to the point that every moment is accounted for. I don't feel that it is possible to go above and beyond as we would like to, when we are worried about hitting our monthly target. We work with people, they and their problems do not always fall into standardised appointment times at certain times of the day, but moving appointment times would not allow us to make the quota for the day. I love my job, and would not like to work anywhere else, and I am aware of why such schemes needs to be put into place, but it has caused worry and stress amongst the team, particularly where roles differ slightly and moral is quite low currently.

We get good training opportunities and I do feel valued by the organisation. I rated likely rather than extremely likely as my only concern is the size of the trust and the impact this has. If I had any concerns to raise this may inhibit me from doing so as there is no other NHS mental health provider in this area.

Supportive management.

It has been a difficult time recently at work with lots of changes. However, I think TEWV try to implement cost efficient care, which is good so long as there is not too much pressure on staff.

TEWV have good support structures in place for their clinicians (efficient admin for example) and generally respond well to requests for change, resource etc.

I like working in TEWV, however they are not very flexible with work colleagues as the previous trust I worked for e.g. working hours, places of work. I may recommend TEWV to friends and family as place to work.

Neither likely nor unlikely

Unorganised and poor pay at times.

Very high pressured environment, with constant increases in workloads without any more capacity in the department to manage this, as a result everything becomes a fire fighting exercise.

It would depend on what kind of person was asking. If it was someone who did not work well in a massive machine-like structure I would be cautious.

It would depend on where they were considering working.

Staff great but targets and short-staffing not good.

Nice workplace however increase in caseload etc. is not appropriate and personally feel this will end in increase in SUI. Discuss issues with manager and nothing is done. Worked in NTW and found them more supportive.

Some teams in the Trust are good because they have good management. Others have poor management.

Too much bureaucracy and not enough focus on what staff need in order to perform well and stay mentally healthy.

Due to a bad experience that my daughter has had been offered employment and then this being retracted.

Service has changed significantly over the 6 years that I have been employed and is now more demanding and stressful.

Again depends where in the trust, doing what.

My current management are absolutely fantastic and very, very supportive. However, staff morale is very low at this moment in time due to the proposals in regards to transforming care and staff being uncertain of their future. The fear of redeployment is abundant and therefore, I have answered as above as neither likely or unlikely, in relation to this.

NHS generally is a stressful working environment - constantly being pressured to deliver more for less.

Positives for working for TEWV the salary and enhancements a secure job with the possibility to develop there is always extra shifts to pick up. Negatives for working for TEWV I have literally never been given 4 weeks notice for my shifts making it difficult to plan ahead for personal event.

Mindful of Transforming Care and possible job changes.

People are free to join and leave enabling them make up their own mind.

Depends on where in the Trust. Some areas yes. Others definite no. Much of answer depends on resources available but second variable is quality and compassion of management.

Hours are not easily worked around childcare/schools. Short staffed.

Would not like to give my views to others as they may seem biased due to my experience with TEWV.

TEWV is a good employer generally however I would be reluctant to recommend working in the NHS due to the current financial restraints imposed by the government and the subsequent pressures place on clinical staff.

Depends in what role they would be working.

The staffing problems affecting the whole NHS impact on the demands on our team, not from our client group, but from management removing us from our role at short notice to cover other areas, when with proactive responses by team managers could have covered the shortages, sometimes weeks ahead.

Change is not being managed well, staff leaving due to concerns over their job security and safety of practice. Sadly no other choice within locality unless we leave the NHS.

Corporate targets are not very motivating - this is probably true across many Trusts.

Staff are overworked, stressed and demoralised and not valued as much as they should be. Expectations of the trust and managers are unrealistic and not achievable in working hours. I have seen many colleagues leave in recent months due to this.

No better or worse than any other employer with regard to employment conditions. Pension for admin is very poor though.

With changes to services, contracts and pension schemes I'm unsure if I would recommend to my family members entering a career in the NHS in general.

Although I wouldn't tell them not to work here, I wouldn't promote it as a place to work. For a mental health Trust it doesn't look after it's staff mental health and wellbeing very well.

I am in the process of taking retirement. I am only 55 and have mental health officer status and wish to return which I have been asking for some months with not much success. Therefore feeling under-valued at this current time.

Depends of the role. The Trust provides a lot of support for clinical staff. There seems little interest in the needs of corporate staff.

Caseloads too high but coming down, systems in place to improve situation.

It is not a reflection on TEWV that I have given a 'neutral' rating - more on the NHS as a whole, where my discipline (psychotherapy) is in danger of disappearing completely.

I have seen three colleagues who are off work with work related stress concerns since joining this team 2 months ago. However, again, the Trust as whole appears to be good organisation to work.

I've only worked for TEWV for 6 months and I agree with their values and their approach to providing a good service. However we are short of staff and as a team, we are not coping with the work that's coming through. This leads to stress, staff sickness and a feeling of not being able to do our jobs properly. We need more workers to cope.

TEWV is good and I would give it a better rating was it not for the RATE of change implemented which is hard to keep up with as a clinician. I am not opposed to change but it needs to be embedded and implemented over a reasonable period of time.

Productivity working demands are very overbearing, and don't allow for workers autonomy, many of my colleagues feel the same as I do that it is taking clinical time away from our diaries every day and is over egged.

Over the last year I have seen the processes taking over patient focus- more time is being spent on 'paperwork'/ visual control etc. than on patient care.

TEWV as a whole is very well run but there are significant problems in the locality where I work.

Very dependant of area of work - would not recommend community CAMHS as a place to work.

I have had both bad and good experiences of working with the trust. I sometimes feel that

staff aren't involved in decision making, or valued, as not always kept fully informed.

Unlikely
Unfilled vacancies, heartless upper management, ever increasing expectations on frontline staff with no support to actually do it, even if we are short staffed. Imposing long days against wishes of staff and evidence base of likely effects.

There is no management and communication is terrible.

Just speaking for my department and not TEWV as a whole.

Same reasons as above. Much emphasis on box ticking, targets and working more efficiently tends to be at the cost of being able to deliver care in a meaningful and individualised way. Ever more detailed performance monitoring and management, increases stress for staff, pushing them further to fulfil the admin demands of demonstrating the appearance of care in order to keep their jobs, whilst job satisfaction decreases as they are aware they have little support and time to really engage with people in a human way, that does not fit into a pre-defined box.

The NHS is very challenging at the moment and I don't see any improvement on the horizon.

So under staffed and there is a prevailing sense we should be a business rather than a health service.

I feel staff are not listened to by higher management and often asked to work in areas they are not trained and do not feel safe. Despite numerous concerns raised about this it continues to happen. Wards and community teams are under staffed and moving staff from other areas to fill gaps is not a longer term safe or productive option. This affects the quality of patient care and safety.

Bullying culture from senior managers, constant criticism, feelings of being undervalued.

Last time I filled in this survey I stated extremely likely as I had encouraged a relative to work in the Trust and they now do. However over the past few months I have been aware of several members of staff leaving the Trust due mainly to attitudes of line managers (not my team) and one friend retiring before she had planned to which is quite sad after over 30 years in this Trust.

I work with a great team of people however the whole of Mental Health services are being stretched beyond capacity.

Due to uncertainty over Langley and where staff will be working.

Unsupportive management, you get moved to different wards all the time, they don't think of the staff, it’s all about money, they always run the unit short, the weekend every ward was one member of staff down which meant that there wouldn't be any response after midnight (as people had stayed back).

Can be a violent place to work.

I love my job but I don't feel that staff are valued particularly. Front line staff need to be able to give out compassion it’s one of the basics and goes to the core of what we do. But to give compassion you need to be given compassion and very often that's not something that happens even on a basic level.

No problems with the trust but due to being from Northumberland, I wouldn't recommend due to the distance to travel for places of work.

I don't think staff's best interests are taken on board.

The trust is too focussed on particular targets and reducing difference. This can get in the way of patient care and staff interacting with patients.

When directorate changes are made they are often done without any thought for those involved in the process which leads to low morale and stress.

Try not to work with family or friends so wouldn't recommend posts to them. Also, they would tend to want to work somewhere where there wasn't such a large geographical patch to cover.

Management has been extremely slow to fill vacancies, presumably to make savings, but do not explain what they are doing or why.

Due to the stressful nature of the environment, pressures to meet performance requirements AND meet patient expectations for quality care.

Most people now work at home entering Paris notes due to the pressure of the job they do not have the time to complete to increased demands and tasks, the trust feels to be target and corporate lead, not a place I would recommend.

I have found TEWV add pressures to their staff unnecessarily i.e. having CPA's every 6 months. I have also had the worst experience of being managed (or not) since working in TEWV and having worked for the NHS for 20 years in several trusts in the country this has been my most negative and unsupported experience to date.

Very stressful and understaffed at times leading to a high workload.

This response reflects my concerns about the organisation as a whole not the team that I work within.

This answer refers to the organisation not the team I work in. The organisation is very driven by numbers and data which misses the quality of the care delivered.

Feel like any innovation is squashed. Staff are not treated as per the trust values by higher management. Don't feel listened too. Professionals who have spent many years in training are not allowed to be autonomous practitioners. PPCS!!! I worry for colleagues in Band 8 positions as they are not listened too or respected.

Again minimal staff to provide care. Strict policies to adhere to and pedantic requirements such as uniform/mufti policies.

The stress levels and workload is becoming ridiculous, there are few opportunities to further your career if you wish to stay with one discipline unless you are prepared to move all over the Trust and we are frequently expected to do work that is higher responsibility than our role covers.

I feel that the trust puts targets and making savings, before staff well-being.

Increasing work pressures unrealistic expectations from management not feeling supported.

I do feel the trust has very good sickness procedures or supportive when someone needs a phase return. The letters you get off HR when you are off sick are impersonal and insensitive to people's personal circumstances. Prior to my sick I had worked in the trust for continuous years with very little sick and this was never taking into consideration. I also did not feel supported by HR when I returned to work during treatment. I have seen other people return to work and be offer non-clinical post which was never discussed with me.

Overwhelmed with work, lack of staff and funding, not enough support.

High caseloads, low support, poor communication.

Change of senior management has led to disappointing changes in the service which is reducing the quality of the service given. This is a huge shame as it was previously very good.

Understaffed, poor working conditions, high turnover of staff.

Pressure of roles, not enough time to undertake clinical roles, increased assaults on staff verbal abuse causing immense strain and emotional stress. Not enough staff on duty and poor retention over 20 staff left in 18 month whom had been in post 10 years plus.

I feel that work is now all about 'numbers' we see and not about quality of what we do. I am currently coming into work early and working at home most nights without pay or recognition for this and I am still behind with my work.

We always expected to achieve the un-achievable with limited staff.

Further funding cuts affecting both patient care and staff morale.

As I am currently under management of change I would not feel able to recommend the trust to friends or relatives applying for a job. These are uncertain times.

See very little of the manager. Not much support around.

Too many changes constantly going on in the trust. Also horrendous case-loads and pressure to work at very high capacity.

Don't use staff potential to the full in relation to qualifications and experience. Inequalities in training support.

Clinical staff are not effectively managed and supervised. In papers one can't find much evidence for this as mostly paper works are done well.

I do not feel well managed and the environment is not fit for purpose (community team). Feels as if changes are being implemented from 'afar' i.e. Middlesborough.

Don't feel valued or supported and a definite divide between different bands.

The stress that we are currently under is severely affecting staff's health and wellbeing.

Too much emphasis on performance and not enough time to engage in client activity. Not particularly supportive as an organisation of staff with difficulties.

Too much pressure to care for clients, little done to staff well-being and manage compassion

fatigue and vicarious trauma.

Extremely unlikely
This is due to the fact that we are overworked and underpaid, the demand on us to always do extra and we never seem to get recognised for doing so. We all do a lot more than we should.

There is a bullying culture which when highlighted to senior managers is not responded to. Absolutely disgraceful.

Current Team management.

Certainly wouldn't recommend due to my experiences of bullying and harassment. TEWV is more concerned about funding and performance than providing good care to patients. It fails to support staff who have high workload and the majority of community staff cannot meet the expectations. When anything goes wrong the blame culture of TEWV comes into play.

Staff carry out their duties in a very professional way but staff are put upon with their caseloads and TEWV are only interested in STATS.

Raising concerns results in retribution and threats. Bullying is the norm, under cover of standard work.

Caseloads are beyond belief staff are exhausted, overwhelmed and crying everyone I know is looking for a new job.

Management are always cutting back, staff are stressed and frustrated with increasing work /caseloads, staff morale low. No one listens. I'm in redeployment due to cut backs but there are no jobs.

Not in CAMHS, no way. I feel ashamed and worn out. I want to leave and am more emotional than I have ever been in my life - and the only thing that changed was moving into CAMHS.

Based on the level of staffing and challenging patients at the current time I would be unlikely to recommend. The staff are expected to work in situations where safety is compromised and in my opinion this is a disaster waiting to happen.

Staffing levels. Unsafe place to work, bad ward manager who had a very autocratic way of working. She does not look after staff.

Poor staffing levels, poor pay scales for staff. No incentive for staff to come and work due to dangerous environment with no support. Staff are treated like a number or a commodity that is used then discarded when burnt out. Majority of experienced long term staff leaving due to poor support and pay structure. Unable to take unpaid breaks away from work area due to poor staffing. Why are the CQC not investigating what the staff have to put up with i.e. serious assaults on staff on the increase.

Understaffing makes the workplace dangerous.

Cliquey/nepotistic, lack of progression, staff are undervalued, innovation isn't encouraged or appreciated.

Due to threatened cuts - staff already work all hours with no lunch breaks and most put in

extra time. The pressure will increase and we are simply not paid enough for that.

Experience with the sickness absence system has been quite negative, appears to be very non-flexible and not taking into account individual needs or situations. Separate to this I have experienced mistakes made with incorrectly being put on a disciplinary sickness warning, causing much additional stress. Also it appears that staff wellbeing is not a priority of the Trust (in my team). I have had positive experience of the Employee support team, however there is a lack of supportive attitude from management when staff raise struggles or difficulties, which is concerning. I have also previously requested and not been eligible for accommodation for a course (necessary to fulfilling the role), due to lack of budget for this. This has been requested for the 2 consecutive days I study in university each week (and have around 4 hours travel time each day, 2 hours each way).

Appalling treatment of staff.

Micro-management bullying culture.

I wouldn't wish nursing on my worst enemy.

While locally the support is excellent, the higher leadership in the trust is not supportive. It uses flawed data and analysis to justify cuts and does not react well to negative feedback.

Ridiculous, physically and mentally unachievable amount of work expected with more and more targets and paperwork expectations all the time. Staff safety is not prioritised.

Stupid long 12 hour shifts which cause problems in delivering patient care.

My problems and concerns are just ignored.

Unmanageable work-load with very little support from management.

Too much red tape, treating patients is an irrelevance what matters is filling in forms that have no bearing on the needs of the patient, the information recorded often does not even hold water from a business modality, senior leadership do not engage staff and listen to needs and importantly the needs of the patients, there are too many made up irrelevant posts filled by unsuitable minions, progression is not based on what a candidate knows but by who they know with the successful candidate selected prior to the post even being advertised,

Because staff do not get treat with respect and don't feel valued. You are just a number.

I do not feel safe when I am at work.

Under resourced at most clinical levels leading to poor working conditions.

Unsupportive management - staff are under-valued and over worked.

Little flexibility, a lot of red tape.

I don't feel that hard work is appreciated. The attitude of some management is that staff can be replaced. Staff wellbeing is overlooked.

Don't know

It depends, if I was to recommend working in the NHS at all, it is highly stressful place to work at present, not enough resources, and more and more pressure. Some services are positive places to work, others not. I find that this is too generalised question to ask.

Again depending on area and place of work.

Additional Comments

I have no problems or issues in the Team I work in. I have an excellent line manager and excellent work colleagues. I still thoroughly enjoy coming to work.

Feel supported by team however not as much support from higher management.

The trust offers non mandatory training to staff but then denies the time to attend training due to lack of staff. There is no opportunities for initiative due to the prescriptive way the trust forces staff to work. Patient care is secondary to meeting targets.

Training depends on the cost if any. Role now appears more focused on targets as opposed to spending quality time with patients.

In IAPT staff are running from this place, look at overall not just at TEWV results and exit interviews.

Good opportunities. Feel valued and respected.

Working with patients directly is rewarding. The team/service is infuriating as things go round in circles. Suggestions and years of work to develop tools eventually thrown out completely. Primarily because of other staff being precious about their roles.

Unable to undertake personal reflective practice and to attend training due to one staff being on duty at times.

Care of our clients are our top priority, however due to increasing workloads, time spent with clients is reducing and time spent on computers is increasing.

TEWV was a great place to work. It has become process driven. There is much rhetoric about compassion but this is just a word bandied about. It is meaningless. In my team people are leaving. The TEWV brand is becoming toxic, recruitment difficult.

Regarding people with lived experience I think it is a very mixed picture across TEWV, the recovery approach needs to be more embedded into services.

There is immense pressure on clinical staff to provide high quality care at the same time as completing mandatory and statutory training requirements. The introduction of 12 hour shifts makes the latter incredibly difficult.

There is limited professional development opportunities for admin staff.

It would appear that professional development is reserved for band 5 or above staff and there are no current opportunities within the trust, for band 3 staff to gain professional qualifications and or training.

I've felt for a long time that there are a lack of progression opportunities for administrative

staff within the Trust. Over the time I've been here I've seen many admin staff move sideways or down but never up.

I like that I am trusted to get on with my job but I dislike being forced to take on roles that are not covered in my pay band - I felt ganged up on my management. I also am annoyed that, despite the Trust wasting money on all sorts of projects.

TEWV are obsessed with over documentation at the expense of vast amounts of face to face time with a client and client care. Every new requirement does not need another document although, it is always possible to come up with a slender argument.

You are told what is going to happen you are not involved or asked what you think and if you do give an opinion if it differs from management you are seen as negative. Staff are leaving very often now because they are not happy which takes an age to replace.

There seems to be very limited for non-mandatory training although manager is able to go to a conference with what appears very little impact on day to day working. Some suggestions are taken up but others in terms of changes to management approach seem.

Too much bureaucracy and the trust is very task orientated.

Sometimes financial constraints mean that my suggestions may not be used.

There are certain members of the team that do not treat me with respect.

Unfortunately as with all work places there are a few who spoil it. It is a struggle to get staff on board with modules brought in by the trust, ignoring emails not getting involved in events. Their lack of participation often sabotages preparation.

I feel that I am able to access other training, however having the time to be able to facilitate such is difficult due to caseload/workload demand and at present, the prospect of doing any additional work outside of my working day, would be exhausting.

My replies reflect the attitude of my current team which is about to be disbanded.

The service takes CPD, training and supervision very seriously. I am encouraged by senior members of staff to achieve my full potential and feel that my ideas, thoughts and opinions are listened to. We get regular 'thanks' for a job well done.

The frustrations with frequent changes to mandatory training (4 new additions in the past few weeks) and inability to access these through ESR are really wearing me down and causing a lot of lost time in service. Why make something that doesn't work mandatory.

Although the care of patients is priority for clinical staff, I do not feel this is always the case for higher management as I feel they only look at numbers and treat people as if they are car parts. I think they often forget we are working with humans.

Sometimes there is a lack of communication about issues which directly affect your work.

I am happy working within the team. However all the new changes, especially PPCS which come from above do not help my work and makes me feel I am not to be trusted to do my job anymore.

I think the trust needs to appreciate the staff that do work hard, there is not enough of this.

Suggestions are hard to implement due to very limited staffing and little support from line manager.

I can't ever see that my responses are reflected in the final collation of data results. No action seems to be taken on my responses.

Due to government policy, reduction in team members and streamlining of services fewer funded courses and time restraints being allowed time off to attend non mandatory training has reduced. Currently feel like being told need to do a better job for what.

My observation is that my team members pay more attention (asked to pay more attention) to completing care documents online and in doing so many have felt that they were unable to prioritise face to face patient time over time spent on computer.

Good at team level.

I have worked for the trust for over 2 years but I am still waiting for an appraisal.

Services lacking resources and staff over stretched.

It is quite stressful at the moment, not enough doctors, trying to cover services, and having performance targets and implementation of new ways of working.

I struggle with the competing demands of being a generic worker and being expected to provide specific Occupational Therapy interventions and assessments. I am also confused about clinical supervision as my colleagues do not attend the peer supervision.

The Trust is good it is the team that lets it down.

Most of my team are resourceful however, some have been quite rude.

Very supportive team and feel at a team level my voice is heard but beyond this feel that the trust do not care about staff and their wellbeing. Staff morale is low.

I came to the trust for a short period of time and have stayed for 13 years, quite remarkable really and certainly not planned. It speaks for itself - I wouldn't be here if I hadn't been happy. Yes, there have been some situations which were better.

I feel listened to and supported.

I am working on a fixed term contract however feel my experience from previous years working in mental health services is valued and utilised within the team.

I can honestly confirm that working for the trust is enjoyable and gives me job satisfaction this together with receiving a good salary makes the trust an excellent place to work.

Time is limited but the CPD provided is very useful for role.

Although able to access CPD and training this is becoming increasingly difficult to fit in with the demands of the service and increasing demands on Affective Teams as a whole with limited resources. Although the team give excellent service.

Not all members of the team are treated equally.

Funding for external training/CPD is not available as a general rule of thumb.

My team is a developing service which allows progression and a level of evolution to our role that is most satisfying to work in. The role is wide and diverse with interesting opportunities.

17 years employed by Harrogate MHS with excellent reputation. Awaiting start date for new position in another team due to being unhappy in current role. New team manager - team dynamics.

Excellent MDT at Woodside.

I have always been very well supported and encouraged to make suggestions to improve my role and attend professional development courses.

I have trouble navigating the mandatory training and have not yet had enough time during a shift to explore CPD stuff.

Again, I agree with all of this about my team. I do not feel that this applies to the wider trust or leadership.

Some suggestions whilst adopted means others are given credit for them. The access and information on ESR is complicated and difficult to access, often not there even when the competence is.

Not team as a whole. Feel very unsupported at times and people are leaving or going on the sick due to hostility and management style, causing stress. Suggestions are made to improve the service but have been ignored at times.

Training dates and place not always accommodating under certain circumstances. Training often cancelled due to staffing.

I have been given one day each week to attend university but over the last 18 months my caseload has never reduced to accommodate this so I end up working at least 6-10 hours extra each week in my own time. Which does not enable me to get the most from my course.

Since splitting of teams according to diagnosis, there is an unequal distribution of extremely risky, volatile patients in affective disorder team and hardly any services geared towards managing repeated self-harmers, violent and personality disordered patients.

I am very new in post so haven't yet had any experience on some of these questions.

I work alone in my role but am supported by my line manager to develop both professionally and personally. I am based with a team who offer support and supervision.

TEWV only accept suggestions from Band 5 and above staff grades. If a lower band makes a good suggestion, their line manager claims it as their own. No recognition is given to the staff member who provided it. There are more managers in roles.

Initiative would be welcomed and I have great ideas for improving practice but we struggle just to stay on top of what we absolutely have to do, there is no time for initiative.

My role as a nurse is undermined, I complete tasks that are then checked, marked as wrong and then changed without any conversation with me to help improve my working in the future. We are monitored on the CCTV.

Within the Trust I am highly supported and treated with dignity and respect at all times. I am in an integrated team with the local authority and do not feel the local authority manager gives me the same opportunities and respect as my trust colleagues.

I am fortunate that the team I work in are forward thinking and open to ideas for change. We are encouraged to make suggestions, which are discussed and in most cases are supported. My manager regular provides feedback on my work which is invaluable.

Due to pressures of PPCS any time away from my desk is not really feasible - work builds up and causes more hassle.

I enjoy working my current team.

There is bullying and harassment almost every day from managers but good support from work peers.

There are members of my team who have strong work ethics and strive to go the extra mile to support staff and patients that said there are many who demonstrate little recognition of their duties and seem not to adhere to any specific plan.

The area I work in does prioritise patient care and go the extra mile for services users as there is a lot of care and compassion within the team, however the expectations that staff will also reach and maintain targets is at times unrealistic.

The team is made up of a variety of individuals, all of whom are willing and keen to help their co-workers, support them and encourage all to thrive in a forward looking, caring way. The team has a deep seated can-do ethos and it is a pleasure to be part of.

Currently only free training is offered to me as I am on a fixed term contract.

Wish there was more one to one patient contact.

Worthwhile making suggestions in my service. Less worthwhile when it involves trying to make changes in corporate services/wider Trust.

I fully believe it is worthwhile making suggestions within my own team. I do not necessarily believe our team is valued or listened to 'higher up' the chain of management.

At present it feels like patient care come second to meeting targets and performance. It also feel like the fundamental aspect of crisis / home treatment i.e. providing an alternative to hospital admission is becoming difficult to achieve through stretch.

I believe this trust to be one of the best NHS organisations to work for with plenty of opportunities for development.

Meeting targets and reducing resources/ cutting cost seem to be the top priority.

The care of patients and service users is TOP priority - to the detriment of staff needs.

I am generally treated with dignity and respect but I have seen colleagues in my team not treated so respectfully in recent months. In a previous role, my manager did not treat me with dignity and respect.

Care of patients marked a bit lower due to issues with high caseloads. Training marked

lower due to no time to do none urgent training.

Have mixed emotions at present due to recent role change after losing Young Onset Dementia team within the organisation.

As a part time worker I feel my working conditions aren't considered as important as my full time colleagues.

A review of the inpatient smoking policy (especially for patients detained under the Mental Health Act) needs to be reviewed.

Leadership is variable. Some great staff but some leadership styles verge on bullying.

At times it has been proven difficult to complete E-Learning due to pressures of the job. This is agreed within the team as saving time in our diaries on occasion becomes difficult to implement.

Ineffective ward manager is leaving staff to have a bad reflection on how they work which is disrupting the team.

There is a lot of bullying, and a culture of blame in my part of the trust which is distressing to witness and occasionally to experience. Often when these concerns are raised they are quashed by managers higher up.

I loved my job but more support needed around staff.

I think it would be great if more training opportunities were available to bank employees who work on a regular basis. I do not believe that bank workers are respected to the same degree of permanent employees.

I only work for two days in the team as I retired 2 years ago but feel that my work /life balance has now improved and I enjoy the two days that I spend with the trust. I feel that I am valued by the team for my experience.

Sometimes - training isn't available in the locality and in timely slots - this can cause additional pressures on the service and incur clinical lost time and excessive travel - this is not lean - I thought there were plans to look at team or area based.

I have worked for this trust for over 20 years, I feel that in this time I have seen little praise of staff who do well at their job. I am aware of the making a difference but I do not feel this represents everyone.

Although there is great opportunity for mandatory training there are several occasions where I have been unable to book training due to availability. First response is a particular issue with regards to this being booked as a back-up is not ideal.

It’s very difficult to obtain funding for CPD. I've had to fund some of my own training - this has never happened before in 26 years service!

Online training has recently been unavailable, or the time constraints make it difficult to complete.

I believe the CRES agenda is effecting the further development of services.

I am able to make suggestions within the team but management do not necessarily listen to them.

There are not many professional development opportunities that people can access themselves.

I have not had a pleasant experience working in this trust as I have been really stressed with the travel to and from Newcastle.

I have been on the list to do training for over a year and every time I chase it up with workforce development I'm told they are waiting to hear which is not good enough as this is on my appraisal to work towards.

Due to low staffing levels there is no scope at present for staff to attend additional training, it is already difficult to attend the mandatory training as there are no amendments to weekly performance targets for this.

Apart from mandatory training there is little open to admin to do training wise. Certainly not locally. If you don't have a car is it not easy to access other areas for training.

In Selby and York area there are currently no opportunities for support workers to apply to do degree or apprenticeship course to become a registered nurse- it also feels that we are kept out of the loop so to speak about any opportunities and senior management.

I feel staff in the team respect me but not current team management.

I think the staff team on Kestrel/Kite have coped well with a difficult period for the ward. The staff are looking forward to a more settled period and being able to spend more time planning activities and outings with the patients.

In the past 18 months I have been offered no non-mandatory training and again this reflects a clear lack of support from the manager, who does not support me to even identify my training needs never mind supporting me with training.

Whilst I feel confident in saying this about the team I work in I do not have that opinion of many other teams in the trust.

The size of the trust mean localities in the south tend to have less training based in their locality.

I have recently moved teams as I was being bullied by my team manager where I was working up until two weeks ago. I have completed this questionnaire in relation to that team as it is very different but unfamiliar in my new team..

I don't feel my future aspirations are taken into consideration despite my input.

Priorities appear to be system objectives and financial over putting patients first.

Cuts in funding for education has reduced opportunities for professional development. The 'hoops' you are expected to go through to access any training with a cost to it just does not seem worth it.

There are issues in relation to adherence of trust values and some staff need to sometimes be reminded. Most staff are upholding of trust values.

When interview stated I would like other possibilities which was encouraged however have been turned down several since.

Staffing is the biggest issue with all escorted leave and escorted visits being cancelled on an almost daily basis.

Training- only training provided for the whole team- find it hard to get time to go to profession specific training Job satisfaction- difficult due to large caseload and stress.

The problem does not lie in my team/department, the issue lies higher up, there needs to be questions asked around senior leadership. The care of the patients is the top priority for my directorate answer strongly disagree.

It's hard as a bank staff to make suggestion or ideas to a team. Training opportunities are difficult for bank staff and is difficult to meet the e-learning requirements now as you have to do it on shift which is impossible or you have to do it in your own time.

I am fortunate to work for a team where the patients and carers are the main priority. However, I have worked in areas where the patient is treated more as a hindrance.

Work within an excellent team.

I can make suggestions, but nothing changes.

I look forward to retirement. I have had enough of not getting right support. Also I have been poorly myself and it was documented that I am a vulnerable person and caring but unfortunately I have worked with some very strong personalities that get away.

Trust main priority is figures not patients. Too many managers who make things worse rather than lead clinicians. Job roles are being down-graded effecting morale. Pay has declined in real terms.

The trust does not offer any CPD that would develop me further.

Workload demand does not currently allow for access to Non-Mandatory and CPD opportunities. Recent appraisal did not support the identification of PDP opportunities as Line Manager was unable to set objectives due to lack of clarity about larger Directorates.

Having recently moved within TEWV to a new location MHSOP Stockton Community Team I believe patients are the priority of my team, I am treated with more respect and dignity, I am listened to and my job satisfaction level has increased tenfold.

I am in a very senior role and I'm aware that many in the Trust wouldn't give such positive answers as I have given!

Hotel Services feel that staff don't count, opinions don't count and what they say goes - (it is what it is)

The top priority for our team seems to be to meet government targets, regardless of how it impacts on service users.

I work in a great team with a great manager, lucky me.

On-line training is at times very frustrating. It can be difficult to access including 'not

available' it is also difficult when hot-desking with a minimum number of available computers. Especially in a community based team.

I have since been redeployed due to Durham and Darlington saving money and have found alternative employment at EIP. I have found the service, the people I am working with and the manager exceptional and very supportive.

Training is restricted to what my role and service delivers. To this end staff can be prevented from training and developing in knowledge and skills that may be for career development elsewhere.

The trust does not manage some HR situations well which can impact on the emotional and psychological wellbeing of individuals involved through prolonged and unnecessarily arduous processes. HR advice is inconsistent and managers are not held to account for it.

Such are the demands on services in this area that the attitude of seeking a means of denying care rather than offering seem to dominate unfortunately. This is a structural imposition rather than individual worker attitude.

I feel my team and managers in my team are supportive and we try our hardest to deliver good quality patient care. I feel it is useless raising thoughts about improvements or to show initiative as higher management are not interested.

Overall I am treated with dignity and respect - however, there is a culture where this is not the case across the service I work in and issues are not dealt with.

I have no issues with the team I work with, they are incredibly supportive and a great bunch of people to work with. My answers reflect my thoughts about the trust and the management teams. I do not feel valued and feel continually checked on.

Don't feel I have as much ability to make and implement suggestions as have previously despite knowing my profession and role better than those making decisions. Treated with dignity and respect by my direct team but not necessarily on a professional level.

It often feels that service KPIs/staff efficiency are more important than the needs of patients.

ITEM NO. 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**20th July 2017**
TITLE:	**Single Oversight Framework**
REPORT OF:	**Phil Bellas, Trust Secretary & Sharon Pickering, Director of Planning, Performance and Communications**
REPORT FOR:	**Information & Assurance**

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

Executive Summary:

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

The purpose of this report is to examine the Trust's position against the requirements of the SOF at the end of Quarter 1, 2017/18.

Whilst recognising the difficulties impacting on internal monitoring, as discussed by the Board in January 2017, it appears that the Trust should maintain its segment 1 (maximum autonomy) rating.

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**20th July 2017**
TITLE:	**Single Oversight Framework**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to examine the Trust's compliance with the requirements of NHS Improvement's (NHSI) Single Oversight Framework (SOF).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The SOF, published on 1st October 2016, sets out NHSI's approach to overseeing NHS Trusts/Foundation Trusts and seeks to enable the regulator to identify where providers may benefit from, or require, improvement support.

2.2 NHSI uses a range of information across the following five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability

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

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

2.5 In previous reports the Board has noted that:

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

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

2.6 The Board is asked to note that the report takes into account relevant feedback received from NHSI following the Quarterly Review Meeting held on 3rd May 2017.

2.7 For completeness, data for the quality and operational performance metrics for 2016/17 (to the extent that it is available) has been provided on Boardpad or circulated under separate cover.

3. KEY ISSUES:

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

3.2 The Board is asked to note that changes to the segmentation of providers are not automatic if a trigger occurs. NHSI takes into account a provider's circumstances in determining the nature and extent of any support required.

Quality of Care

Information used by NHSI	Triggers
▪ CQC information ▪ Other quality information ▪ 7-day services	▪ CQC 'inadequate' or 'requires improvement' assessment in one or more of: safe; adequate, effective; or responsive ▪ CQC warning notices ▪ Another other material concerns identified or relevant to, CQC monitoring processes e.g. civil or criminal cases raised, whistleblowers etc. ▪ Concerns arising from trends in quality indicators ▪ Delivering against an agreed trajectory for the four priority standards for 7-day hospital services

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

3.4 The Board is asked to note that:

(a) The Trust's segmentation reflects its "good" CQC rating.

(b) Assurances have been received from the Trust's compliance team that there are no concerns in relation to the achievement of targets within the CQC Action Plan at present. A copy of the Action Plan has been provided to NHSI.

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

(d) No concerning trends have been identified on the quality indicators.

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

3.5 Overall, there are considered to be no risks to the Trust's segment 1 position on this theme at this time.

Finance and Use of Resources

3.6 The Trust's position on the SOF requirements in relation to finance and use of resources is set out in the Finance Report (agenda item 10).

3.7 Discussions have been held with NHSI on sustaining financial performance, staffing pressures and estates issues and these matters are expected to continue to be closely monitored by the regulator.

Operational Performance

Information used by NHSI	Triggers
▪ NHS Constitution standards ▪ Other national targets and standards	Failure to meet the trajectory for a metric for at least two consecutive months (quarterly for quarterly metrics), except where the provider is meeting the NHS Constitution standard

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

3.9 Board Members will recall that risks to the achievement of the IAPT recovery target have been highlighted in previous reports. Based on internal monitoring the Trust achieved target (50.92%) on this indictor for Quarter 1, 2017/18; however, compliance is expected to continue to be challenging going forward. NHSI has requested, and has been provided with, copies of action plans and it is likely that the regulator will pay close attention to the Trust's ongoing performance on this indictor.

3.10 It is considered that the Trust should continue to maintain its segment 1 position on this theme.

Strategic Change

Information used by NHSI	Triggers
Review of sustainability and transformation plans and other relevant matters	Material concerns with a provider's delivery against the transformation agenda, including new care models and devolution

3.11 Board Members are asked to note that there is a lack of clarity in the SOF on the assessment and application of the triggers; however, no concerns have been raised by NHSI.

Leadership and Improvement Capability

Information used by NHSI	Triggers
▪ Findings of governance or well-led review undertaken against the current well-led framework ▪ Third party information, eg Healthwatch, MPs, whistleblowers, coroners' reports ▪ Organisational health indicators ▪ Operational efficiency metrics ▪ CQC well-led assessments	▪ Material concerns ▪ CQC 'inadequate' or 'requires improvement' assessment against 'well-led'.

3.12 The Board is asked to note that:

(a) At this time there is no known third party information (e.g. GMC, PHSO, Healthwatch, HSE, complaints, whistleblowers, medical royal colleges) which suggests governance implications in the Trust.

(b) Following the CQC inspection in January 2017 the Trust was rated "good" in the well-led domain.

(c) There are considered to be no risks arising from the Trust's position against the organisational health indicators (see Annex 1).

(d) A separate progress report on the few remaining actions contained in the York and Selby Quality Governance Action Plan is provided under Agenda Item 14.

3.13 A briefing on the initial findings and recommendations arising from the Independent Governance Review of the Trust is due to be provided by Grant Thornton following the meeting. No material issues have been raised, to date, during informal feedback.

3.14 Overall, no risks have been identified with regard to the Trust's position on this theme.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** There are no direct CQC implications arising from this report; however NHSI's aim is to help providers attain and maintain CQC ratings of "good" or "outstanding".

4.2 **Financial/Value for Money:** Assessments of the Trust's position against the SOF's theme of finance and use of resources are provided in the Finance Reports.

4.3 **Legal and Constitutional (including the NHS Constitution):** The legal basis for enforcement action in relation to NHS Foundation Trusts remains unchanged. This means that, for example, a Foundation Trust will only be in segments 3 or 4 where it has been found to have been in breach or suspected breach of its licence.

4.4 **Equality and Diversity:** Information on delivering Workforce Race Equality Standards (WRES) will be used as part of assessments under the Leadership and improvement capability theme; however, no further information on this matter is included in the SOF.

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are risks arising from the Trust not being able to accurately assess its position against the requirements of the SOF in view of the lack of information on the construction of metrics; information not being available from the national sources identified; and/or data quality issues.

6. CONCLUSIONS:

6.1 Overall, there are no material changes which are expected to impact on the Trust's segment 1 position under the SOF; however, the report highlights certain areas which are expected to continue to be subject to close monitoring by NHSI.

7. RECOMMENDATIONS:

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

Phil Bellas, Trust Secretary
Victoria Reed, Corporate Performance Manager

Background Papers:
Single Oversight Framework published by NHS Improvement on 30th September 2016

SINGLE OVERSIGHT SCORECARD - QUALITY INDICATORS - 2017/18

Annex 1

All Providers																	
Quality Indicators	**SOF Source**	**Other known source**	**Freq.**		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
Staff Sickness	NHS Digital	n/a	M & Q		-	-	-	-	-	-	-	-	-	-	-		ESR Data Warehouse - last published data February 17
		Finance Return	M & Q			4.40%	4.80%										Finance Return to NHS Improvement - not required to report in April. May and June figures are a month behind
		Trust Dashboard (month behind)	M & Q		4.49%	4.39%	4.80%										IIC reporting a month behind
Staff turnover (Finance Return)	NHS Digital	Finance Return	M & Q			0.50%	0.60%										Finance Return to NHS Improvement - not required to report in April. May and June figures are a month behind
Executive Team turnover	Provider Return	n/a	M		0.00%	0.00%	0.00%										
NHS Staff survey	CQC	n/a	A														Staff survey not yet undertaken
Proportion of temporary staff	Provider Return	n/a	Q			1.49%											Finance Return to NHS Improvement (tbc)
Aggressive cost reduction (million)	Provider Return	n/a	Q			1.486											Finance Return to NHS Improvement (tbc)
Written compliants - rate	NHS Digital	n/a	Q														Last published data is December 2016
Staff and Friends and Family test % recommended - care	NHSE	n/a	Q								No Staff FFT in Q3						NHS Staff Survey carried out in Q3
		Strategic Direction Perf. Report	Q								No Staff FFT in Q3						
Occurrence of Never Event	NHS Improvement	Governance	M		0	0	0	-	-	-	-	-	-	-	-	-	
NHS England/NHS Improvement Patient Safety Alerts outstanding	NHS Improvement	Governance	M		0	0	0	-	-	-	-	-	-	-	-	-	
Mental Health Providers																	
Quality Indicators	**SOF Source**	**Other known source**	**Freq.**		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Comments**
CQC inpatient/mental health and community survey	CQC	n/a	A														Survey not yet published
Mental Health scores from Friends and Family Test - % positive	NHSE	n/a	M		88.63%	-	-	-	-	-	-	-	-	-	-	-	Latest published data April 2017
Admissions to adult faciliites of patients who are under 16 years old	NHS Digital	n/a	M											-	-	-	No public data available
		PARIS	M		0	0	0										Data from Paris

Quality Indicators	SOF Source	Other known source	Freq.	Standard	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Comments
CPA follow up - proportion of discharges from hospital followed up within 7 days (all discharges treated as being on CPA)		UNIFY		95%													Data states the source is UNIFY (data submitted quarterly) -submission for Q1 2017/18 due 17th July, will be published 11th August
		pre validated IIC			**92.67%**	**94.29%**	**96.71%**										
		post validated IIC			**94.76%**	**95.92%**	**98.35%**										
% clients in settled accommodation	NHS Digital	n/a	M				-			-			-				Latest published data March 2017
		IIC	M		87.97%	86.47%	81.90%										Percentage of people on CPA in settled accommodation
% clients in employment	NHS Digital	n/a	M				-			-			-				Latest published data March 2017
		IIC	M		13.16%	13.42%	13.28%										Percentage of people on CPA in employment
Potential under-reporting of patient safety incidents	NHS England Dashboard	n/a	M											-	-	-	No public data available

SINGLE OVERSIGHT SCORECARD - OPERATIONAL PERFORMANCE METRICS - 2017/18

Annex 2

Mental Health Providers																	
Operational Performance Metrics	**SOF Identified source**	**Other Identiifed Source**	Freq.	**Standard**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Comments**
Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards	UNIFY2 and MHSDS	n/a	**Q**	**95%**													Data states the source is UNIFY (data submitted quarterly) - submission for Q1 2017/18 due 17th July, will be published 11th August
		pre validated IIC			**91.67%**	**90.38%**	**85.98%**										
		post validated IIC			**97.14%**	**98.08%**	**96.89%**										
People with a first episode of psychosis begin treatment with a NICE recommended package of care within 2 weeks of referral	UNIFY2 and MHSDS	n/a	**Q**	**50%**	**69.70%**	**78.26%**	**70.18%**										This data is currently published from the Unify submissions that are made monthly
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **inpatient wards**	Board declaration but can be triangulated with results of CQUIN audit	pre validated PARIS	**Q**	**90%**	-	-	-										
		post validated PARIS			-	-	-										Internal assessment of the audit sample that was submitted to the Royal College of Psychiatry - was expected confirmation April 17, still not received
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **early intervention in psychosis services**		pre validated PARIS	**Q**	**90%**	-	-	-										
		post validated PARIS			-	-	-										Results of the internal audit that will be reported as part of the CQUIN
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in **community mental health services (people on CPA)**		pre validated PARIS	**Q**	**65%**	-	-	-										
		post validated PARIS			-	-	-										Internal assessment of the audit sample that was submitted to the Royal College of Psychiatry - was expected confirmation April 17, still not received
Complete and valid submissions of metrics in the monthly MHSDS submissions to NHS Digital - identifier metrics	MHSDS	IIC	**M**	**95%**	**99.60%**	**99.57%**	**99.58%**										No public data available, data shown is internal
Complete and valid submissions of metrics in the monthly MHSDS submissions to NHS Digital - priority metrics	MHSDS	n/a	**M**	**85%**													No public data available and construction unknown
IAPT/Talking Therapies - proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	IAPT minimum dataset	n/a	**Q**	**50%**	**45.94%**												Data only available until April on IAPT minimum dataset
		Internal Reports		**50%**	**49.50%**	**50.63%**	**52.48%**										
IAPT/Talking Therapies - waiting time to begin treatment (from IAPT minimum dataset) - **within 6 weeks**	IAPT minimum dataset	n/a	**Q**	**75%**	**97.22%**												Data only available until April on IAPT minimum dataset
		internal IAPT reports		**75%**	**97.79%**	**97.14%**	**98.06%**										
IAPT/Talking Therapies - waiting time to begin treatment (from IAPT minimum dataset) - **within 18 weeks**	IAPT minimum dataset	n/a	**Q**	**95%**	**99.54%**												Data only available until April on IAPT minimum dataset
		internal IAPT reports		**95%**	**99.88%**	**99.76%**	**99.89%**										

ITEM NO. 13

BOARD OF DIRECTORS

DATE:	**20th July 2017**
TITLE:	**Workforce Race Equality Standard**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Consultation and Decision**

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

Executive Summary:

This report provides the latest available Workforce Race Equality Standard (WRES) information in respect of TEWV, includes an update about progress made with the current action plan and proposes an updated action plan for endorsement by the Board of Directors.

The much larger number of BAME staff survey respondents who participated in the 2016 staff survey, compared to the 2015 staff survey, is thought to have helped provide more representative feedback within the WRES which overall is more positive than before though further attention and action on the part of TEWV is needed.

Recommendations:

(1) To note the contents of the report and to comment accordingly.

(2) To endorse the attached action plan, subject to the identification of any amendments that may be agreed.

MEETING OF:	**Board of Directors**
DATE:	**20th July 2017**
TITLE:	**Workforce Race Equality Standard**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide the Board of Directors with the latest information about the Workforce Race Equality Standard (WRES) and to seek support for the content of the latest TEWV WRES action plan that is attached to this report.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 TEWV is required to publish its latest WRES information set (2016/17) and associated action plan by 1st August 2017. The request for Board of Directors approval of the latest proposed action plan has been preceded by consultation that included consultation with the Quality Assurance Committee.

3. KEY ISSUES:

3.1 Appendix 1 includes the latest TEWV WRES information that has been provided by NHS England and a copy of a draft TEWV action plan produced in response to this information.

3.2 Indicator 1 in the WRES has recently been amended to identify Agenda for Change band to band comparisons between White and BAME staff in place of the previous indicator that sought to identify whether the overall Trust workforce was representative of the community served.

3.3 An analysis of the reasons why BAME staff entered the formal disciplinary process (Indicator 3) has recently been completed. An analysis of the nine BAME staff disciplinary cases did not identify any examples of discriminatory decision making. Three of the nine cases led to disciplinary action being taken which means that the same proportion of disciplinary cases involving BAME staff resulted in disciplinary action as these cases that involved white staff. Different commissioning managers were involved in these cases and the TEWV disciplinary investigation team was involved in all of these cases. No grievances or other forms of complaint were made by those involved in these cases though it is acknowledged that this in itself is not evidence that they were free from discrimination. Further enquiry and review is needed to better understand why proportionately more BAME staff than white staff are the subject of disciplinary proceedings in the first instance.

3.4 The most recently available information identifies that white staff are more likely to access non-mandatory training and Continuing Professional Development than BAME staff. This is a reversal of the previously reported position (Indicator 4).

3.5 The percentage of staff experiencing bullying and harassment or abuse from patients, relatives or the public in the last 12 months (Indicator 5) increased for both BAME and White staff, from 27.27% and 20.88% to 37.23% and 27.95% respectively. This is believed to be the indicator that requires the most attention which was acknowledged by the Quality Assurance Committee at its meeting in June 2017.

3.6 The gap between the percentage of BAME staff and White staff experiencing harassment, bullying or abuse from staff in the last 12 months (Indicator 6) has narrowed appreciably from 22.72% to 1.87%. The narrowing of the gap is due primarily to a reduction in the staff survey reported amount of harassment, bullying or abuse suffered by BAME staff with only 3.68% of the change attributed to an increase in such behaviours being reported by White staff. The much higher staff survey sample size is believed to have been an important factor in the related BAME staff survey score.

3.7 TEWV has recently received confirmation of NHS Health Research Authority approval for a study into 'Racial, disability and sexual orientation in the NHS; Understanding the differences in the national NHS staff survey and the Staff Friends and Family Test in Tees, Esk and Wear Valleys NHS Foundation Trust.' It is proposed that this research activity will form an important part of the TEWV WRES action plan.

3.8 TEWV has recently been chosen to be an NHS Employers Diversity and Inclusion Partner for 2017/18. This will involve TEWV working with NHS Employers and twenty nine NHS trusts to support system wide efforts to improve the measurement of diversity and equality across the health and social care system. TEWV will get access to specialist support and guidance and be involved in pioneering and championing existing measures and standards as well as preparing for implementation of new standards such as the Workforce Disability Equality Standard. It is believed that involvement in these activities can only help to enhance knowledge and embed good diversity and equality practices within TEWV.

4. IMPLICATIONS:

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

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

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

4.4 **Equality and Diversity:** The report addresses important equality and diversity issues

4.4 **Other implications:** None identified.

5. RISKS: None identified.

6. CONCLUSIONS:

6.1 The latest TEWV WRES information includes both positive and negative changes when comparing 2016/17 WRES information with that of the previous year. The most pressing issue to tackle is believed to be that of the high percentage of BAME staff being bullied and harassed by patients, relatives or members of the public.

7. RECOMMENDATIONS:

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

7.2 To endorse the attached action plan, subject to the identification of any amendments that may be agreed.

David Levy
Director of Human Resources and Organisational Development

Background Papers:

Technical Guidance for the NHS Workforce Race Equality Standard (WRES) March 2017 – NHS England

NHS Workforce Race Equality Standard 2016 Data Analysis Report for NHS Trusts – NHS Equality and Diversity Council

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

APPENDIX 1

WORKFORCE RACE EQUALITY STANDARD

2016/17

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

1. Background narrative

a. Any issues of completeness of data

In relation to Indicator 4 the relative likelihood of BAME staff accessing non- mandatory training and CPD compared to White staff. The Trust does not have a process for monitoring requests or approvals for non- mandatory training and holds no data on this. The trust has included a specific question within its staff friends and family test Staff were asked 'I am able to access job relevant non- mandatory training and /or continuing professional development opportunities.' The calculation in this document has been based on the number of positive responses to this question in q4 16/17. In total 2667 white staff replied to this question and 93 BAME staff.

b. Any matters relating to reliability of comparisons with previous years

The national staff survey was sent to all staff this year. 101 of those completing it identified as BAME which gives the trust much greater confidence in the results compared to last year when there were very few BAME staff included in the survey sample.

2. Total numbers of staff

a. Employed within this organisation at the date of the report

6585

	b. Proportion of BME staff employed within this organisation at the date of the report	
	4%	

	3. Self-reporting a. The proportion of total staff who have self-reported their ethnicity	
	99.3%	
	b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity	
	No	
	c. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity	
	The level of self – reporting is very high.	
	4. Workforce data	

a. What period does the organisation's workforce data refer to?	
1st April 2016 to 31st March 2017	

5. Are there any other factors or data which should be taken into consideration in assessing progress?	
6. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

WORCEFORCE RACE EQUALITY STANDARD ACTION PLAN – 2017/18

	Indicator.	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, compare the data for White and BME staff.				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	 Detailed staff breakdown Race2.do	1.69% of non-clinical and 4.77% of clinical BAME staff in bands 8-9 & VSM posts compared to overall workforce of 3.91%	The percentage of BAME in the trust is affected by the large numbers of medical staff who are from BAME backgrounds. Very few BAME staff are in bands 8b and above for both clinical and non-clinical staff. For non- clinical staff there are no BAME staff in bands 6 and 7	1. The development of a TEWV BAME leadership and development programme for staff on Agenda for Change pay bands 5-7. This will be ready to roll out in October 2017. 2. The actions to be carried out in respect of indicator 2 will complement those within this indicator.
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	White staff are 1.32 times more likely to be appointed from shortlisting compared to BAME staff.	White staff are 1.43 more likely to be appointed from shortlisting compared to BAME staff.	There has been a slight improvement in this indicator however more work is needed.	1. A review of recruitment decisions where shortlisted BAME job applicants were not appointed to posts during the last 12 months. This was completed by end May 2017.

					2. The development of an action plan based on the findings of the review. This will be completed by end of September 2017 and presented to BOD in November 2017. .
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from ta two year rolling average of the current year and the previous year.	BAME staff are 2.08 times more likely to enter the disciplinary process than white staff	BAME staff are 2.03 times more Likely of entering the formal disciplinary process compared to White staff	BAME staff are more likely to enter the disciplinary process than white staff. The reasons for this are unclear and work is needed to understand the causes.	1. Undertake root cause analysis of reasons BAME staff have entered formal disciplinary process, identifying any hot spots. This will be completed by end of May 2017 2. Undertake research with BAME staff to seek their views for increased likelihood of them entering disciplinary process. This will be completed by September 2017. 3. Develop action plan to address this. This will be completed by end of September 2017 and presented to BOD in November 2017. .
4.	Relative likelihood of staff accessing non-mandatory training and CPD.	The likelihood of White staff accessing CPD and non- mandatory training and CPD is 0.34	The likelihood of White staff accessing CPD and non- mandatory training is 0.86 compared to 1 for	This year information for this indicator has been pulled from a response to a question in the staff FFT as	1.Research is being undertaken with BAME staff which will seek their views on the likelihood of

		compared to 0.29 for BAME staff. White staff are more likely to access CPD and non-mandatory training compared to BAME staff.	BAME staff. White staff are less likely to access CPD and non-mandatory training compared to BAME staff.	the trust has no other way of recording this information at present.	them accessing non-mandatory training and CPD. This will be completed by September 2017. 2. Develop action plan to address this. This will be completed by end of September 2017 and presented to BOD in November 2017 3.The development of a trust BAME leadership and development programme for bands 5-7. This will be ready to roll out in October 2017.
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White:27.95% BAME: 37.23%	White: 20.88% BAME: 27.27%	The difference between the experience of white and BAME staff has remained static. This difference is mirrored in incidents recorded on DATIX. The trust is concerned at the high levels of all staff who experience harassment, bullying or abuse from patients, relatives or the public	1.A review of the Trust's Positive approaches training will be undertaken so that the training includes: • How to respond to and manage verbal abuse and aggression. • The debriefing tool for both staff and patients following incidents to include verbal abuse

					and aggression. This will be completed by December 2017 2. A review will be undertaken of the process in place for supporting staff following harassment, bullying or abuse by patients, relatives or the public. Following this a guidance document will be produced. This will be completed by end of January 2018. 3. To include any proposals arising from the TEWV Way engagement activities about mutual expectations of behaviour for staff and service users. This information will then be publicised on posters throughout the trust. To be implemented by the end of March 2018. 4. For the Executive Management Team to receive monthly reports from DATIX on the levels of harassment, bullying and abuse of staff from

					protected groups by patients, relatives or the public.
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	White: 17.32% BAME: 19.19%	White: 13.64% BAME: 36.36%	The gap between BAME and white staff's experience of bullying, harassment and abuse has greatly decreased since last year. The number of staff completing the staff survey who identify as BAME has increased from 11 to 101.	Although the difference between BAME and white staff's experience of staff on staff bullying has greatly decreased the trust is still concerned at the level of bullying within the trust is to develop a Bullying and Harassment Reporting and Resolution Procedure by Sept 2017
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	White: 93.65% BAME: 94.29%	White: 93.26% BAME: no data	There is no significant difference in the reported experience of BAME and white staff	No action to be taken in relation to this indicator at present.
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	White: 5.02% BAME: 3.06%	White: 5.03% BAME: 0.00%	White staff are more likely to have experienced discrimination at work from manager/ team leader or other colleagues.	No action to be taken in relation to this indicator at present.
	Board representation indicator: For this indicator, compare the difference for White and BME staff.				
9.	Percentage difference between the organisations' Board voting membership and its overall workforce.	Percentage difference between the organisations' BAME Board voting membership, non- voting membership and NEDs and its overall BAME workforce is -4.0%	Percentage difference between the organisations' BAME Board voting membership and its overall BAME workforce is -4.0%	There are no BAME members of the trust board and this has not changed since last year.	The TEWV talent management action plan is to include actions to address this issue. These actions will be presented to the Talent Management Board in November 2017

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**20th July 2017**
TITLE:	**York and Selby Quality Governance Action Plan**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Assurance and Decision**

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

Executive Summary:

In accordance with the regulator's usual processes, the Trust, in January 2016, provided Monitor (NHS Improvement) with a Quality Governance Action Plan as part of the York and Selby Transaction.

At its meeting held on 25th April 2017 (minute 17/104 refers) the Board considered a progress report on the delivery of the Plan. It was agreed that most of the actions had been completed; however, there were three where further assurance was required.

This report provides an update on these remaining actions to enable the Board to determine whether there is now sufficient assurance to enable the Action Plan to be signed off as completed.

Recommendations:

The Board is asked to determine, based on the assurances provided in this report, whether the York and Selby Quality Governance Action Plan should be signed off as completed.

MEETING OF:	**The Board of Directors**
DATE:	**20th July 2017**
TITLE:	**York and Selby Quality Governance Action Plan**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide an update on progress on the few remaining actions of the York and Selby Quality Governance Action Plan with a view to enabling the Board to sign it off as completed.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 In January 2016 the Trust provided Monitor (NHS Improvement) with a Quality Governance Action Plan as part of the York and Selby Transaction. This was in accordance with the regulator's usual processes for significant investments set out in its (then) Risk Assessment Framework.

2.2 At its meeting held on 25th April 2017 (minute 17/104 refers) the Board considered a progress report on the delivery of the Plan. It was agreed that most of the actions had been completed; however, there were three where additional assurance was required as follows:

(a) Elections to be held for Public and Staff Governors in York and Selby.
(b) The implementation of a programme to fully apply Trust policies and procedures in the York and Selby Locality.
(c) Programme of work to be developed and implemented to embed the Trust's approach in the York and Selby Locality.

3. KEY ISSUES:

Elections

3.1 The Board is asked to note that, following the election of Governors for the Selby Public Constituency in June 2017, there is now full representation (Public, Staff and Appointed Governors) for the York and Selby Locality on the Council of Governors.

3.2 This action has, therefore, been completed.

Application of Trust Policies and Procedures

3.3 In April 2017 it was reported that the majority of Trust Policies and Procedures had been adopted in the Locality from 1st October 2015; however, the assimilation of human resources policies, whilst progressed, had not been fully completed as they were subject to review with the Trade Unions (due to links to the TUPE regulations).

3.4 The Director of Operations for York and Selby has now advised that the human resources policies have been reviewed and assimilated.

3.5 It is now considered that this action has been completed.

Embedding the Trust's Approach in the Locality.

3.6 In the previous report the Board was advised that work was ongoing in relation to:

- Resolving some reporting issues e.g. data quality linked to the transition of PARIS.
- Engagement of staff on key metrics e.g. improvement in clustering, responses to Friends and Family Test surveys, etc.
- The development of Locality specific action plans in line with Commissioner or Locality requirements e.g. IAPT action plan, CAMHS action plan and EIP action plan.

3.7 Since that time additional support has been confirmed for teams where there are continuing issues with performance/quality metrics.

3.8 The Director of Operations has advised that the present position is that reporting to the Quality Assurance Committee is continuing; there has been an improving trajectory on key performance indicators; and various inputs have been agreed as part of action plan development, including Organisational Development, Training, QIS support and Information & Performance work. The approach has been assimilated into Trustwide action plans rather than being a separate process.

3.9 It is considered that the position reached is now that of "business as usual".

4. IMPLICATIONS:

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

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

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

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are risks that if, following review, NHS Improvement considers that the Quality Governance Action Plan has not been delivered to its satisfaction, it might regard this as a governance failure.

6. CONCLUSIONS:

6.1 The Trust gave an undertaking to deliver the Quality Governance Action Plan as part of the York and Selby Transaction.

6.2 Whilst there are a number of challenges in the Locality, as reported to the Quality Assurance Committee and, where appropriate, escalated to the Board, these are operational issues outside the scope of the Action Plan.

6.3 Overall, it is now considered that all actions have been completed or have become “business as usual”.

7. RECOMMENDATIONS:

7.1 The Board is asked to review the assurances provided in this report and determine whether the York and Selby Quality Governance Action Plan can be signed off as completed.

Phil Bellas,
Trust Secretary

Background Papers:
York and Selby Quality Governance Action Plan
Report on the Single Oversight Framework (including progress on the York and Selby Quality Governance Action Plan) to the Board meeting held on 25th April 2017.

ITEM NO. 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**20th July 2017**
TITLE:	**Board Performance Evaluation Scheme**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Assurance**

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

Executive Summary:

Each year the Board undertakes a review of its performance, and that of its Committees, in accordance with the Code of Governance.

This report focusses on:
(1) The assessment of Board effectiveness.
(2) A cross-cutting review of the performance assessments of the Board's Committees.

For completeness it also includes summaries of the results of the individual assessments of the Board's Committees and the actions being taken forward in response to them.

Overall, the results of the evaluation are positive; however, there are a couple of issues which might be worthy of further consideration i.e. the standard of reports and engagement with service users and carers.

Board Members will be aware that, over the last couple of months, Grant Thornton has been conducting an independent governance review of the Trust. Whilst the evaluation would, usually, be used to identify developmental actions (if required), this year the Board is asked to note the results of, and assurances provided by, the assessment but to consider their implications in the context of the findings of the governance review.

Recommendations:

The Board is asked to receive and note this report.

M4EETING OF:	**The Board of Directors**
DATE:	**20th July 2017**
TITLE:	**Board Performance Evaluation Scheme**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present the results of the Board Performance Evaluation Scheme (BPES) for 2016/17.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Main principle B.6.a of the Foundation Trust Code of Governance states that *"The Board of Directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors."*

2.2 The Board uses an approach, known as the Board Performance Evaluation Scheme (BPES), which was originally developed by Deloittes LLP, to undertake the assessment.

2.3 This report focusses on Board effectiveness and potential cross-cutting issues arising from the assessments of the Board's Committees. Information is also provided on the actions being taken forward by the Committees in response to their own results.

2.4 Only summary information is provided in this report. The full schedules of the results have been made available on Boardpad or circulated under separate cover. Please note that the scoring of each question is based on a maximum of 4.0 points.

2.5 Board Members will be aware that Grant Thornton has been undertaking an independent governance review of the Trust over the last couple of months. The initial findings and recommendations of this review will be presented at a session following the meeting. In view of this, the Board is not asked to identify any developmental actions at this time but to note the results of, and assurances provided by, the evaluation and to consider their implications (in due course) in the context of the findings of the governance review.

3. KEY ISSUES:

Board Effectiveness

3.1 Summary of Results:

	Number	**Percentage**
Number of **maximum** scores achieved i.e. 4.0	15	41.7%
Questions showing an **increase** in score on the previous year	14	38.9%

Questions showing a **decrease** in score on the previous year	10	27.7%
Questions showing **no change** on the previous year	12	33.3%
New questions	0	0

3.2 Board Members are asked to note that:

(a) The results were positive.

(b) Most of the changes to the scores were not material either positively or negatively.

3.3 However, there are two issues which it is considered should be brought to the Board's attention as follows:

(a) The standard of reports.

Question 18 sought Board Members views on the statement "All reports draw the Board's attention to the key pieces of information that require consideration by the Board before it can reach a decision in no more than two sides and clearly state whether a matter is for decision, debate or information".

The score for this question reduced from 3.46 in 2015/16 to 3.00 in 2016/17 (and provided the lowest score overall).

The Board is asked to note that:

- The issue (together with the volume of paper) tends to be a low benchmark in Board performance evaluations.
- The score for the question increased last year but has now fallen back to pre-2015/16 levels.
- The length (and content) of certain reports has been discussed on a number of occasions over the last year.

(b) Service User and Carer Engagement.

Question 3 sought Board Members views on the statement "This Board regularly hears about the needs and expectations of service users and their carers".

The score for this question (3.27) was the second lowest overall and represented a slight deterioration on the previous year.

Whilst Board Members recognised that there are a number of mechanisms for hearing the views of service users and carers (e.g. Board visits) a number of comments were made about whether these arrangements were sufficiently regular and systematic and whether the information received should be given greater prominence.

The Committees

3.4 A summary of the results of the BPES for the Board's Committees, and action being taken in response to the assessments, is attached as Annex 1 to this report for information.

3.5 The Board is asked to note that:

(a) The results were, generally, positive.

(b) The majority of changes to the scores for individual questions were not material.

(c) There were no themes where scores had decreased across the Committees.

(d) Scores had increased (or maximum scores were maintained) in relation to:

- Clarity of the role and key aspects of the work performed by individual committees
- The adequacy of induction programmes
- The appropriateness of the amount of consideration by the Board of matters within a committee's remit
- The timeliness of the distribution/formatting of reports and the quality of minutes
- Adherence to the Trust's values
- The integrity of Members
- The effectiveness of decision making

3.6 It is considered that the Board can be assured that its Committees are performing effectively.

4. IMPLICATIONS:

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

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

4.3 **Legal and Constitutional (including the NHS Constitution):** The BPES supports compliance with the Code of Governance as required under the Trust's Constitution.

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 The results of the BPES for 2016/17 provide assurance that the Board and its Committees continue to perform effectively; however, there are a couple of issues which the Board might wish to consider further in the context of the findings of the independent governance review.

7. RECOMMENDATIONS:

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

Phil Bellas,
Trust Secretary

Annex 1

Board Performance Evaluation Scheme 2016/17

Summary of the Results and Agreed Actions for the Board's Committees

	Audit Committee		Resources (Investment Committee)		Quality Assurance Committee		Mental Health Legislation Committee	
	Number	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
Number of **maximum** scores achieved	**48**	**85.7%**	**13**	**65%**	**12**	**42.9%**	**6**	**30%**
Questions showing an **increase** in score on the previous years	**14**	**25.0%**	**9**	**45%**	**26**	**92.9%**	**10**	**50%**
Questions showing a **decrease** in score on the previous years	**1**	**1.8%**	**2**	**10%**	**1**	**3.6%**	**10**	**50%**
Questions showing **no change** on the previous years	**32**	**57.1%**	**8**	**45%**	**1**	**3.6%**	**0**	**0**
New questions	**9**	**16.1%**	**0**	**0**	**0**	**0**	**0**	**0**

Key Actions	The Internal Auditors to bring forward a revised set of performance metrics to the next meeting of the Committee in September 2017.	Work to be undertaken to promote the availability of the charitable funds more widely in the Trust	A representative group of QuAC members and LMGB leads to meet to look at further improvements around providing assurance to the Committee building on the work undertaken approximately 18 months ago	Developmental workshop to be held following the MHLC meeting on 19/10/17. The event will focus on strengthening the assurances provided to the Board and clinical input into the work of the Committee

ITEM NO. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**20th July 2017**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

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

Executive Summary:

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

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**20th July 2017**
TITLE:	**Report on the Register of Sealing**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

3. KEY ISSUES:

3.1 The Trust Seal has been used as follows:

Number	Date	Document	Sealing Officers
305	11.7.17	Licence to carry out works at Lime Trees, 31 Shipton Road, York	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary
306	11.7.17	Contract documents relating to Acomb Gables and Acomb Health Centre, York	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary
307	11.7.17	Contract documents relating to Huntington House, York	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary
308	11.7.17	Contract documents relating to the West Park Seclusion Suite	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary
309	11.7.17	Licence to carry out works at 2 Oak Rise, York	Drew Kendall, Interim Director of Finance and Information Phil Bellas, Trust Secretary

4. IMPLICATIONS:

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

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

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

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

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

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution
Seals Register

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25 July 2017**
TITLE:	**Policies Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

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

Executive Summary:

The policy paper contains the following information:

2 policies that have undergone full review and required re-ratification:

- **FIN-0004-v5 Travel and Subsistence Policy**
- **CLIN-0080-v2 Young People Admitted to Adult Inpatient Wards**

2 policies that have had minor amendments:

CORP-0064-v1.1 Duty of Candour
CORP-0043-v8.1 Incident Reporting and Serious Incident Review Policy

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meeting held on 05 July 2017

DATE:	**25 July 2017**
TITLE:	**Policies and Procedures Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

1. INTRODUCTION & PURPOSE:

The purpose of this report is to advise the Board of Directors on the policies and procedures that have been ratified by the Executive Management Team.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 It is important that the Trust policy portfolio is updated and revised in a timely way to ensure best practice, current legislation and regulation is reflected in policy content. Policies no longer required to control and assure practice should be terminated and withdrawn from the portfolio.

2.2 Following the last revision of the Trust's Integrated Governance arrangements, it was agreed that the Executive Management Team ratify all new and revised Trust policies and procedures.

2.3 Each policy and procedure ratified by the Executive Management Team will have gone through the Trust's consultation process.

2.4 Currently all corporate Trust policies are ratified by the EMT on behalf of the Board of Directors, following approval by the appropriate specialist committees and groups. All decisions regarding the management of the policy framework must be ratified by the EMT.

3. KEY ISSUES:

3.1 The following have undergone full review and require re-ratification:

FIN-0004-v5 Travel and Subsistence Policy
Review date: 05 July 2020

The following amendments have been made:
Para 3.1.2 - clarification of the process for completing expense claims
Para 3.3.1 – sentence added regarding the responsibility of both the driver and manager to ensure they meet all the requirements detailed in Annex F before undertaking business mileage
Para 5.9.1 – clarification that parking expenses can be claimed
Para 5.9.2 – sentence added that employees can choose whether they receive a monthly payment upon the submission of a mileage return, or a lump sum of 70% of 2 years estimated payments.

CLIN-0080-v2 Young People Admitted to Adult Inpatient Wards
Review date: 05 July 2020

The policy has undergone full review in line with current best practice and regulatory requirements. Wording has been added regarding training needs and monitoring.

3.2 The following have had minor amendments:

CORP-0064-v1.1 Duty of Candour
Review date: 02 November 2019

Minor amendments have been made to meet the recommendations of the Duty of Candour Audit carried out by Audit One.

- Amended definition of safety incident in line with the Regulation to notifiable safety incident
- Removed the duplication in wording on 1 -7
- Added the amended Duty of Candour checklist re changes in working 1 – 7 from the Incident Reporting policy
- Removal of typographical errors
- Strengthened legal information from training in the Duty of Candour Master Class
- Added a section on what actions the CQC can take if the Trust does not comply with Duty of Candour

CORP-0043-v8.1 Incident Reporting and Serious Incident Review Policy
Review date: 18 January 2020

This policy has had minor review to reflect the amendments to the Duty of Candour:

- Amended the Duty of Candour checklist as above
- Amended Duty of Candour actions in line with the changes to the Duty of Candour policy as above
- Amended the Deaths in Custody section
- Added statement on learning lessons monitoring
- Added LeDeR process
- Addition of Flow Charts for Reporting of Incidents and Head of Service Reviews

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

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

4.2 Financial/Value for Money:

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

4.3 Legal and Constitutional (including the NHS Constitution):

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

4.4 Equality and Diversity:

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

4.5 Other implications:

None identified

5. RISKS:

None identified

6. CONCLUSIONS:

The decisions detailed above made at the EMT meeting on 07 June 2017 have been presented for ratification.

7. RECOMMENDATIONS:

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

Author: Colin Martin
Title: Chief Executive