Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 27TH OCTOBER 2015 VENUE: LAKE HOUSE, 20 MANOR COURT, SCARBOROUGH BUSINESS PARK, EASTFIELD, SCARBOROUGH, YO11 3TU AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the meetings of the Board of Directors held on **14th** and **29th September 2015**.		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To consider the report of the Quality Assurance Committee.	**RS/EM**	**Attached**
Item 7	To consider the Nurse Staffing Report.	**EM**	**Attached**
Item 8	To consider progress reports on: (a) The implementation of Clinical Supervision. (b) The Clinical Risk and Harm Minimisation Project.	**EM**	**Attached**
Item 9	To consider a progress report on the Out of Locality Admissions Action Plan.	**BK**	**Attached**
Item 10	To approve the Trust's response to the consultation on the Deprivation of Liberty Safeguards being undertaken by the Law Commission.	**EM**	**Attached**

Performance (10.40 am)

Item 11	To consider the summary Finance Report as at 30th September 2015.	**CM**	**Attached**

Item 12	To consider the Trust Performance Dashboard as at 30th September 2015.	**SP**	**Attached**
Item 13	To consider the Trust Workforce Report as at 30th September 2015.	**DL**	**Attached**

Refreshment break

Governance (11.10 am)

Item 14	To approve the Quarter 2, 2015/16 Risk Assessment Framework submission to Monitor.	**PB**	**Attached**
Item 15	To consider a progress report on the Governance Action Plans.	**CM**	**Attached**
Item 16	To consider the Information Strategy and Governance Assurance Report.	**CM**	**Attached**

Items for Information (11.30 am)

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

Item 18 To note that the next meeting of the Board of Directors will be held on Tuesday **24th November 2015** in the Board Room, West Park Hospital Darlington at 9.30 am.

Confidential Motion (11.35 am)

Item 19 **The Chairman to move:**

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

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

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

Any documents relating to the Trust's forward plans prepared in accordance with paragraph 27 of schedule 7 of the National Health Service Act 2006.

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

Mrs. Lesley Bessant
Chairman
21st October 2015

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

MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS HELD ON 14TH SEPTEMBER 2015 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 10.00 AM

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

In Attendance:
Mr. P. Bellas, Trust Secretary
Mrs. R. Hill, Project Director, York and Selby
Mrs. M. Pears, Ward Hadaway Solicitors

The Chairman welcomed Mrs. Hill and Mrs. Pears to the meeting.

15/242 DECLARATIONS OF INTEREST

Mrs. Matthews declared that she was employed by the City of York Council in a position of influence on policy.

No matters relating to the local authority were discussed during the meeting.

15/243 CONFIDENTIAL MOTION

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

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

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

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

Following the transaction of the confidential business the meeting concluded at 11.15 am.

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 29TH SEPTEMBER 2015 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 AM

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

In Attendance:
Mrs. B. Gibson, Public Governor for County Durham
Mr. P. Bellas, Trust Secretary
Mrs. J. Jones, Head of Communications
Mrs. K. Ord, Deputy Trust Secretary
Mr. M. Heard, Patient and Public Involvement & Recovery Liaison Officer

15/245 APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr. H. Griffiths, Non-Executive Director, Mr. M. Hawthorn, Non-Executive Director and Mr. D. Jennings, Non-Executive Director.

15/246 MINUTES

***Agreed** – that the public minutes of the meetings held on 23rd July and 18th August 2015 be approved as correct records and signed by the Chairman.*

15/247 PUBLIC BOARD ACTION LOG

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

Arising from the report:

(1) The Board noted that the information contained in the Equality Data Document (minute 15/16 - 27/1/15 refers) had been included in the information pack for the Board Business Planning event to be held on 6th and 7th October 2015.

(2) Mrs. Moody advised that the variances on nurse staffing fill rates in the County Durham and Darlington Locality, highlighted during the consideration of the annual nurse staffing report (minute 15/200 - 23/7/15 refers), arose from less staff being required than included in the baseline establishment due to the reduction in the number of MHSOP beds in December 2014.

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

Action: Mr. Bellas

15/248 DECLARATIONS OF INTEREST

No declarations of interest were made with regard to the matters included on the public agenda for the meeting.

15/249 CHAIRMAN'S REPORT

Mrs. Bessant:

(1) Drew attention to her report to the meeting of the Council of Governors held on 22nd September 2015.

(2) Reported that she had recently spent time in North Yorkshire, including a couple of days in Scarborough, during which she had:

(a) Visited the CAMHS teams in the Locality.

It was noted that the key issue arising from these visits were the concerns expressed by staff about achieving target, and sustaining performance, on waiting times.

(b) Presented a "Living the Values" award to Amanda Lyon, a housekeeper for Rowan Lea, Cross Lane Hospital, for her kind, caring and positive approach to meeting the needs of patients on the ward.

(c) Visited Cross Lane Hospital, Scarborough.

The Chairman advised that, during the visit, staff in the Estates and Facilities Management Department had raised a number of issues which she had passed on to relevant Executive Directors.

(d) Visited the CMHT at The Anchorage in Whitby.

It was noted that the staff were very positive about partnership working but had raised concerns about the team's caseload.

(3) Advised that she had participated in her first set of consultant interviews for a position in CAMHS on 28th September 2015.

Mrs. Bessant advised that, although service users and carers had been involved in recruitment activities for some time, this was the first time that they had met with the interview panel. The insight provided in their feedback on the candidates had been very useful and informative.

15/250 GOVERNOR ISSUES

No issues were raised.

15/251 QUALITY ASSURANCE COMMITTEE

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

(1) The confirmed minutes of its meeting held on 2nd July 2015 (Appendix 1 to the report).

(2) The key issues discussed by the Committee at its meeting held on 3rd September 2015.

(3) The Patient Safety and Patient Experience Data Report for June and July 2015 (Appendix 2 to the report).

Arising from discussions:

(1) In response to the request received from HMP Northumberland, Mr. Levy undertook to discuss the potential use of premia as a recruitment incentive with Mr. Buckley (Director of Operations for Forensic Services).

Action: Mr. Levy

(2) Mrs. Moody undertook to review and provide a briefing to the Board on the variations between Localities in the results of the MHSOP falls audit and the actions being taken by the Clinical Directorates to address the compliance issues found.

Action: Mrs. Moody

(3) Clarity was sought on the Executive Management Team's (EMT) position on whether training on the Mental Health Act (MHA) should be incorporated within the Trust's mandatory training scheme (Committee minute 15/126 – 2/7/15 refers).

In response it was noted that, based on feedback provided by the CQC, the EMT had concluded that staff had a good understanding of the MHA and it was considered unnecessary for the subject to be included in the mandatory training scheme; however, the matter would be kept under review.

(4) In response to a question with regard to the development of a business case to provide a countywide street triage service in North Yorkshire, Mr. Martin advised that:

(a) Although the Police, taking into account the Crisis Concordat, had promoted the development of a countywide service, it was not expected that the Trust would contribute to its funding.

(b) The Trust needed to be mindful that other services, e.g. CAMHS, would be a higher priority if any additional CCG funding became available.

15/252 NURSE STAFFING REPORT

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

In introducing the report Mrs. Moody:

(1) Reported that, in accordance with the discussions under minute 15/229 (18/8/15), the monthly reports had been rationalised to focus exclusively on providing assurance on the safety of staffing levels. The analysis of staffing data against a range of quality metrics would now be included in the 6 and 12 monthly review reports.

(2) Drew attention to the key issues identified in the report including:

  (a) The slight deterioration across all of the staffing indicators during the month.

  (b) The increase in the number of wards showing "red" fill rates. Of these, the County Durham and Darlington and Forensic Services Localities had the lowest and highest numbers of "red" rated wards respectively.

  (c) Cedar Ward having the lowest fill rate for the month.

  It was noted that this was due to the incorrect configuration of the Healthroster system in that it was set up based on two registered nurses whilst the service was working towards only having one registered nurse on night shifts.

(3) Provided assurance that the triangulation of staffing and quality data had not identified any direct risks or implications to patient safety or experience within the reporting period.

The focus of discussions was on the lack of registered mental health nurses (RMNs) and the impact of this on the use of agency staff within the Trust.

Mr. Barkley reported that approximately 10% of RMN positions in North Yorkshire and York were vacant. As the York and Humber LETB only commissioned 40 RMN places a year from York University, and there was a 20% drop out rate, it would take approximately two years to fill every vacancy even if all newly qualified nurses were employed by the Trust.

It was also noted that there was significant competition for newly qualified nurses from private and third sector providers in the Locality which had resulted in none from the last cohort being recruited into NHS mental health services.

Mrs. Moody advised that, whilst newly qualified nurses often chose to work, initially, in the private and third sectors due to higher levels of remuneration, there was evidence that they filtered back to the NHS over time for a number of reasons including their experience of the preceptorships and training.

The Non-Executive Directors highlighted that difficulties were being experienced in recruiting qualified nurses in other Localities. For example, during a recent Directors' visit, services in North Durham had suggested that the Trust should also focus on attracting newly qualified nurses from Northumbria University as those graduating from Teesside University were, generally, not interested in working in the area.

In addition:

(1) The Chairman highlighted the information included in the Strategic Direction Scorecard report (see minute 15/256 below) on the number of patients feeling unsafe and considered that the reliance on bank and agency staff might be contributing to this.

(2) Mrs. Pickering considered that it was important to recognise the impact of staff transferring to newly commissioned services which could create shortfalls elsewhere.

(3) The Board noted that there were also risks to the availability of nurses due to the age profile of the staff with 20% of RMNs and one-third of ward managers being eligible to retire in the next four to five years.

In terms of addressing these issues:

(1) With regard to the York and Selby Locality:
   (a) It was noted that discussions were being held on the financial and non-financial benefits which could be offered to newly qualified nurses in response to the higher starting salaries paid by private and third sector providers.
   (b) Mr. Barkley advised that, in view of the issues being experienced in the Locality, he was urging the LETB to dramatically increase the number of student places commissioned from York University.

   The Board supported this approach.

(2) Mr. Levy reported that:
   (a) A paper on nurse recruitment and retention was due to be considered by the Quality Assurance Committee at its meeting to be held on 1st October 2015.
   (b) An analysis of nurse recruitment and retention over the last two years showed that the Trust was in a relatively positive position; however, localised transient issues could emerge.

(3) It was suggested that, in view of the difficulties being experienced, consideration should be given to over recruitment.

   In response:
   (a) It was noted that the over recruitment of staff was already being undertaken in IAPT services in County Durham and Darlington and Forensic Services.
   (b) Mr. Levy advised that:
      - Work was being undertaken to seek to address recruitment issues including the development of values based centralised recruitment, which was due to be piloted. This approach was based on candidates, who were assessed as being appointable, but who were not offered a position in the first instance, being placed on a call off list and offered any suitable employment available within the Trust for up to six months after their initial interview.
      - 9% more nurses had been recruited compared to the previous year.

With regard to other matters included in the nurse staffing report Board Members:

(1) Expressed their disappointment about the increase in the number of “red” rated wards but noted that, as a similar pattern had occurred during August 2014, the summer holiday period might have contributed to the position.

(2) Sought clarity on the tools suggested by NHS England to provide information on the direct clinical contact time nursing staff spent with patients.

Mrs. Moody advised that NHS England had provided evidence based tools for measuring activity on mental health wards e.g. observations, activity, etc. Other tools for measuring direct contact time were also available based on the same methodology as the "Productive Ward".

(3) Questioned whether further analyses of contact time by registered nurses would be undertaken to corroborate the findings of the observational studies carried out in forensic services (minute 15/200 – 23/7/15 refers).

Mrs. Moody responded that:
(a) The observational studies had found low levels of direct contact time with patients by registered nurses but this was in line with the national picture.
(b) It was planned to pilot two evidenced based tools for measuring contact time in two wards.

(4) Questioned, with reference to an SUI on Cedar Ward, whether SUI reviews would consider the extent bank staff usage had contributed to the incident.

Mrs. Moody responded that bank staff usage would be considered as part of the root cause analysis of an incident and undertook to review whether it had contributed to the reported incident on Cedar Ward.

Action: Mrs. Moody

(5) Questioned whether the high use of agency staff had contributed to the number of incidents requiring control and restraint on Rowan Ward.

On this matter:
(a) Mrs. Moody undertook to provide an analysis on the number of incidents of control and restraint compared to the use of temporary staffing in the next six month nurse staffing report.

Action: Mrs. Moody

(b) Mr. Kilmurray undertook to ask the Quality Assurance Groups (QuAGs) to consider the extent the nurse staffing situation on a ward contributed to the number of incidents of control and restraint when reviewing the monthly reports provided to them on that matter.

Action: Mr. Kilmurray

15/253 MENTAL HEALTH LEGISLATION COMMITTEE

The Board:
(1) Received and noted the report of the Mental Health Legislation Committee including:
(a) The confirmed minutes of the meeting held on 27th April 2015 (Appendix 3 to the report).
(b) The key issues considered at the meeting held on 27th July 2015.

(2) Considered the draft Associate Hospital Managers Policy (Appendix 2 to the report).

Mr. Simpson and Mrs. Moody commended the draft Policy to the Board as, once approved, it would enable the recruitment of Associate Hospital Managers to recommence and assist in reducing pressure on the existing cohort arising from the number of panel hearings.

Whilst supporting the draft Associate Hospital Managers (AHMs) Policy Board Members questioned:

(1) Whether an increase in the number of panels AHMs were required to undertake, from the present 12 per year, would provide a better use of the resources available.

Mr. Simpson responded that:

(a) The MHA Department considered that undertaking 12 panels per year was sufficient for AHMs to remain sufficiently knowledgeable and experienced to undertake the role.
(b) Some AHMs would have difficulty in meeting an increase in requirements as they were only willing to participate in panels within their own Locality.
(c) Increasing the number of panels which AHMs were required to undertake would not have a financial impact as they were only paid an honoraria for their attendance and expenses.
(d) The view of the MHA Department was that having a larger pool of AHMs would provide easier recruitment to panels.

(2) Whether the number of AHMs quoted in the report, 38, was inflated as it would include the Non-Executive Directors and not all of them undertook the role.

The Chairman considered that the MHA Department tended to call on Non-Executive Directors to participate in panels in the first instance and this approach was unsustainable given other calls on their time.

Mr. Simpson advised that this issue had been discussed by the MHLC. He considered that increasing the pool of AHMs, through recruitment activity linked to the approval of the revised Policy, would reduce the calls on Non-Executive Directors.

Agreed – *that the revised Associate Hospital Managers Policy (as set out in Appendix 2 to the above report) be approved.*

Action: Mrs. Moody

15/254 FINANCE REPORT AS AT 31ST AUGUST 2015

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

Mr. Martin reported that:

(1) Overall the Trust's financial position was tracking close to plan.
(2) The outcome of a review of the Trust's CRES position, undertaken during September 2015, would be presented in the October Finance Report.
(3) Whilst CRES identified as at 31st August 2015 was ahead of plan, the position was likely to deteriorate as some schemes were difficult to deliver. Further

information on this matter would be provided at the forthcoming Business Planning Event.

(4) In accordance with minute 15/208 (23/7/15) the report included the Trust's position against both the Continuity of Service Risk Rating and the new Financial Sustainability Risk Rating (FSRR) which had been introduced by Monitor in its Risk Assessment Framework during Quarter 2, 2015/16. The position on both these risk ratings was 3 in accordance with plan.

It was noted that Mr. Martin intended to include the Trust's positions on both risk ratings in the next Finance Report and then to only provide the position on the FSRR thereafter.

In response to questions Mr. Martin reported that:

(1) The position on receivables over 90 days past their due date usually reflected the delays in receiving payments from statutory bodies rather than from individuals. Although performance at 5.8% was marginally above the 5% risk tolerance set by Monitor, there was considered to be no risk to receiving the payments.

(2) There was a general national pattern of deterioration in the financial risk ratings of providers which was expected to worsen during the second half of the year.

(3) There would be significant detrimental implications for the Trust if its FSRR reduced to 2.

He advised that the metrics included in the FSRR were interrelated. If the surplus margin was managed down it would reduce CRES requirements but also restrict the availability of capital resources. Seeking to reduce the risk rating would also reduce the Trust's ability to respond to any worsening of the financial environment.

(4) Agency spend, at 1.9% of total staffing costs, appeared low in comparison to the total hours worked by agency staff (0.31%) in the nurse staffing report (see minute 15/252 above); however:

(a) Expenditure on nurse agency staff was quite low and localised.

(b) A significant proportion of agency staffing expenditure was on medical staffing.

(c) Actual agency expenditure on administrative and clerical staff, for example linked to IT projects, was higher than for nursing staff.

15/255 PERFORMANCE DASHBOARD AS AT 31ST AUGUST 2015

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

In introducing the report Mrs. Pickering:

(1) Advised that, as agreed at the Board Seminar held on 18th August 2015, the SWEMWBS and HONOS indicators had been removed from the Trust Dashboard.

(2) Provided clarity that, although the Trust had not achieved the 50% recovery rate (KPI 7) overall, the IAPT services in the South Tees, Harrogate and Rural District and Vale of York CCG areas had achieved the target.

Arising from the report:

(1) Board Members recognised that the Trust's overall position against the indicators included in the Performance Dashboard was improving.

(2) With regard to waiting times it was noted that:
   (a) There had been an improving trend on both targets over the last three months.
   (b) The slight deterioration in performance during August 2015 was attributed to the summer holiday period.
   (c) There was evidence that actions taken to address waiting times in CAMH services were starting to have an impact with all referrals to the services in the Tees Locality being seen within four weeks and those in the County Durham and Darlington Locality being seen within 5 to 6 weeks.

   The Chairman highlighted the importance of ensuring the services were resilient in order to sustain and further improve performance.

The Chairman also welcomed the improvements to the narrative reporting in the Performance Dashboard report.

15/256 STRATEGIC DIRECTION SCORECARD

Further to minute 15/230 (18/8/15) consideration was given to the Trust's position against the metrics included in the Strategic Direction Scorecard for Quarter 1, 2015/16.

Mrs. Pickering reported that, in response to comments received at previous meetings, the format of the report had been changed to provide:

(1) Additional qualitative information to demonstrate progress on delivering the Trust's Strategic Goals.

(2) Information on progress on the priorities in the Business Plan which had been previously provided in a separate report.

(3) Additional information on how the Trust was seeking to respond to areas of concern.

(4) Assurance on those metrics where the position had changed following the end of the Quarter.

Board Members welcomed the improvements to the format of the report.

The discussions focused on KPI 3 (Percentage of patients reporting "yes always" to the question "did you feel safe on the ward?").

In response to a question from the Chairman on how services supported patients feel safe following incidents on wards it was noted that:

(1) Support was offered to individual patients.

(2) Emphasis was placed on improving communications so that patients felt confident about raising issues with teams. This was a tenet of the safer wards initiative.

(3) The work being undertaken on positive behavioural support, which was being rolled out across the Trust, was intended to create a calmer environment on wards resulting in patients being less likely to witness incidents and, therefore, feel unsafe.

(4) Work was also being undertaken to address environmental issues, e.g. shared rooms, which contributed to patients feeling unsafe.

Board Members also:

(1) Sought clarity on the statement in the report that "upon review of the 9 comments received from the completed surveys (for the Evergreen Centre) it is clear that some of the data is not valid."

In response it was noted that the Evergreen Centre provided CAMH services and it was evident from the review that certain responses to the survey could not be relied upon.

(2) Raised concerns about the delays to signing off of NICE baseline assessment tools (BATs) being due to the scheduling of meetings of consultative groups.

It was noted that the Clinical Audit and Effectiveness Team was considering how the BAT assessment processes could be improved.

Agreed -

(1) that the changes to the Business Plan, as set out in Appendix 1 to the above report, be approved; and

(2) that the target for KPI 28 (attendance rate at meetings of Health and Well-being Boards) be amended to 90% as, on reflection, the target of 100% was unrealistic.

Action: Mrs. Pickering

15/257 REGISTER OF INTERESTS OF THE BOARD OF DIRECTORS

The Board received and noted the Register of Interests of the Board of Directors.

The Chairman advised that her entry in the Register required amendment as her husband had retired from his position at Northumbria University and was now undertaking consultancy work for the University of Teesside.

Mr. Bellas undertook to amend the Register accordingly.

Action: Mr. Bellas

15/258 TERMS OF REFERENCE OF THE BOARD'S COMMITTEES

Further to minutes 14/291 (30/9/14) and 14/331 (28/10/14) the Board reviewed the terms of reference of its Committees.

Copies of the present terms of reference were provided as Annexes 1 to 6 to the covering report.

It was noted that no changes were proposed to the terms of reference of the Committees at this time; however, the Chairman would be hosting a meeting in December 2015 to consider the operation of the Quality Assurance Committee after its first year of operating under revised arrangements.

***Agreed** – that, noting the review of the operation of the Quality Assurance Committee to be held in December 2015, the terms of reference of the Board's Committees, as set out in Annexes 1 to 6 of the report, be confirmed.*

Action: Mr. Bellas

15/259 BOARD BUSINESS CYCLE

Consideration was given to the Board Business Cycle for the period October 2015 to December 2016 including:

(1) The proposed dates, venues and matters to be considered at formal Board meetings which took into account the expansion of the Trust into York and Selby (as set out in Annex 1 to the report).

(2) The programme of matters to be discussed at Board Seminars (as set out in Annex 2 to the report).

The Board discussed the suitability of the proposed date of the Board meeting in December 2016, the 20th of the month, due to its proximity to Christmas. It was confirmed that the meeting should be held on the proposed date.

***Agreed -** that the Board Business Cycle, as set out in Annexes 1 and 2 to the above report, be approved.*

Action: Mr. Bellas

15/260 USE OF THE TRUST SEAL

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

15/261 POLICIES AND PROCEDURES RATIFIED BY THE EXECUTIVE MANAGEMENT TEAM

The Board received and noted the report on the Executive Management Team's ratification of policies and procedures.

15/262 DATE AND TIME OF NEXT MEETING

It was noted that the next meeting of the Board of Directors would be held, in public, at 9.30 am on Tuesday 27th October 2015 in Lake House, 20 Manor Court, Scarborough Business Park, Eastfield, Scarborough.

15/263 CONFIDENTIAL MOTION

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

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

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

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

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

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

Following the transaction of the confidential business the meeting concluded at 12.40 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: 27th October 2015

Title: Board Action Log

Lead: Phil Bellas, Trust Secretary

Report for: Information/Assurance

This report includes/supports the following areas:

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

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

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

Board of Directors Action Log

RAG Ratings:

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

Date	Minute No.	Action	Owner(s)	Timescale	Status
29/07/2014	14/233	Further Board discussions to be held on the key factors influencing trends on unexpected deaths	MB	~~2015~~ March 2016	See also minute 15/C/267 - 29/9/15
30/09/2014	14/284	A briefing to be provided to a Board Seminar on Equality and Diversity	MB/DL	Dec-15	
24/03/2015	15/68	Provision of a report on the updated culture metrics	DL	24/11/2015	
26/05/2015	15/131	Consideration to be given to alternative approaches to responding to the continuing low fill rate for registered nurses at Springwood e.g. compensating staff for travelling	DL	Oct-15	Completed Outcome of the review reported to the QuAC on 1/10/15
26/05/2015	15/132	A progress report on the implementation of the waiting times action plans (including data on performance by team over time) to be presented to the Board	BK	Nov-15	
26/05/2015	15/133	Future reporting of data on additional hours worked by staff to differentiate between full and part-time staff	DL	Nov-15	
26/05/2015	15/133	Consideration to be given to providing greater flexibility within the Trust's 12 hour shift system as part of the Working Longer Review	DL	Mar-16	
26/05/2015	15/133	Progress report on the implementation of the Trust Composite Staff Action Plan to be presented to the Board	DL	Nov-15	

Date	Minute No.	Action	Owner(s)	Timescale	Status
26/05/2015	15/141	The contents of and language used in the quarterly Information Strategy and Governance Assurance Reports to be less technical	CM	From Oct 2015	See agenda item 16
23/06/2015	15/170	Information on the three wishes raised by teams to be included in future reports on Directors' visits	BK	Jun-16	
23/07/2015	15/202	Updates on the Clinical Supervision and Clinical Risk and Harm Minimisation Workstreams to be provided to the Board on a quarterly basis	EM	To commence 27/10/2015	See agenda item 8
29/09/2015	15/251	The potential use of premia as a recruitment incentive, as suggested by HMP Northumberland, to be discussed with Mr. Buckley (Directors of Operations)	DL	Nov-15	
29/09/2015	15/251	The variations between Localities in the results of the MHSOP falls audit and the actions being taken by Clinical Directorates to address the compliance issues found to be reviewed and a briefing on these matters to be provided to the Board.	EM	Oct-15	
29/09/2015	15/252	The contribution of the use of bank staff to an SUI on Cedar Ward to be reviewed	EM	Oct-15	
29/09/2015	15/252	An analysis of the number of incidents of control and restraint compared to temporary staff usage to be provided in the next six monthly nurse staffing report	EM	26/01/2016	
29/09/2015	15/252	The QuAGs to be asked to consider the extent the nurse staffing situation on a ward contributed to incidents of control and restraint during their reviews of the latter issue.	BK	-	Completed
29/09/2015	15/253	Approval of the revised Associate Hospital Managers Policy	EM	-	Approved
29/09/2015	15/256	Approval of changes to the Business Plan as set out in the Appendix to the Strategic Direction Scorecard Report	SP	-	Approved
29/09/2015	15/256	Approval of a change to the target of KPI 28 (attendance rate at meetings of Health and Wellbeing Boards) in the Strategic Direction Scorecard from 100% to 90%	SP	-	Approved
29/09/2015	15/258	Confirmation, subject to the outcome of the review of the operation of the QuAC, of the terms of reference of the Board's Committees	PB	-	Approved

Date	Minute No.	Action	Owner(s)	Timescale	Status
29/09/2015	15/259	Approval of the Board Business Cycle (Oct 2015 to Dec 2016)	PB	-	Approved

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Item 6

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: **Tuesday, 27 October 2015**

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

Lead Director: **Richard Simpson, Non-Executive Director**

Report for: **Assurance/Information**

This report includes/supports the following areas:

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

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

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting: **Tuesday 27 October 2015**

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

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting on 01 October 2015.

2. BACKGROUND INFORMATION

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

3. KEY ISSUES

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

Durham and Darlington LMGB – where key issues raised were:

1. There was an ongoing difficult and challenging complainant from a community team, which had included the use of social media and threatening language directed at members of staff by name. The police had been involved and the social media activity is being monitored on a daily basis.
2. The demand for services across CYPS and AMH. There were actions in place to address this, including ongoing discussions with Commissioners.
3. Recruitment continued to be a challenge.
4. Fast track plans for the implementation of the Transforming Care agenda were currently underway, looking at local plans and contingency services that would be needed in the community.
5. There had been a very positive MHA review on Birch Ward, on 20 August 2015, with some positive feedback from patients.
6. There had been a case in the press recently regarding an NHS homicide review of a patient charged with the death of a lady in residential care home. It was noted that the care home provider was the lead for the investigation rather than TEWV.

7. There were currently delays for patients securing wheelchairs as there were pressures on the adaptation services. The Trust Occupational Therapy lead was working actively with community services to try and come up with some solutions.

3.2 Tees LMGB – where key issues raised were:

1. Increased referrals to both access and affective services, particularly in South Tees after TEWV had ceased to be the provider of IAPT services at the end of June 2015.
2. Issues with access to EMI nursing beds due to long waiting lists in Hartlepool and the subsequent impact on MHSOP services. There were currently 2 EMI nursing homes closed to admissions; however 1 was expected to re-open shortly.
3. There had been significant improvement in waiting times in Stockton, however the key issue would be around sustaining these improvements with increasing demand.
4. There had been a collective grievance submitted from staff at Roseberry Park concerning rest breaks. New rest break guidance had been issued to staff, this had been agreed at EMT, however despite consultation it had not been agreed with Staff Side.
5. There had been pressures on Westerdale South, due to vacancies and sickness.
6. Plans to close the steel works on Teesside could have an impact on referrals to services which would be monitored.

4. PHYSICAL HEALTHCARE AND WELLBEING REPORT

1. One of the issues raised at the quarterly Physical Healthcare and Wellbeing Group was the need to develop an SBARD around an agreed data set for taking patient blood tests on admission to ensure standardisation.
2. The procedures around the early detection and management of the deteriorating patient had been updated.
3. Following recommendation by QuAC in April 2015 consideration had been given to developing some KPIs for the Physical Healthcare and Wellbeing Group; however it was not felt that this would be appropriate for this particular Sub group of the Quality Assurance Committee.

A review of this group, along with other Sub-groups of QuAC would take place over the autumn months of 2015.

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

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

5.1 Clinical Effectiveness Group

1. Baseline audits had revealed low compliance with recording the 6 physical healthcare parameters, which were a requirement of the Lester tool and would be monitored as part of the national audit in December 2015 for CQUIN 4a.
   The extensive Physical Healthcare Project would continue across the Trust and Specialties would facilitate clinical actions to mitigate identified risks.

2. There were currently discussions underway around developing a framework for managing/monitoring NICE guidelines in the Trust.

5.2 Patient Safety Group

1. There were currently major changes taking place to the Datix system to improve the ability to both provide assurance and for analysis of any patterns and trends.
2. All outstanding incidents on Datix had now been cleared and the focus would be on monitoring the actions in place.
3. There was ongoing debate around SUIs and the need for clear and concise information to be entered onto Paris. All incidental findings would be reviewed by the Head of Nursing in localities to identify any patterns, which would be fed into Trust wide quality improvement work.
4. There would now be a separate allegation stream within the Datix system. This would prevent it being reported to NRLS or IIC until such time it became a proven incident.
5. The Committee received a copy of the Patient Safety Bulletin which members found to be very informative and agreed for it to be circulated to staff.

5.3 Patient Experience Group

1. The outstanding actions around complaints had steadily decreased, with no overdue outstanding action plans in September 2015. 1 overdue complaint in Durham was currently being resolved by the Complaints Manager.
2. All Wards had achieved 100% Friends and Family results for 2 consecutive months, 5 CMHTs had achieved 100% and 1 at 90%.

5.4 Safeguarding Children and Adults - Verbal Updates.

The Committee heard that there were 5 ongoing serious case reviews that the Trust was involved in, 3 in Redcar and 2 in Durham.

A 'Review of health services for Children Looked After and Safeguarding in Middlesbrough' had been published on 15 September 2015 with a recommendation for TEWV and the CCG, which was to ensure that early help services for children requiring access to Tier 1 and 2 services for emotional health and well-being were strengthened'. CAMHS had submitted their action plan and good evidence had been found around multi-agency working, with positive feedback around adult mental health services.

For both safeguarding teams (adults and children) the workload had been increasing around domestic abuse, with a large number of individuals (both victims and perpetrators) being known to the Trust.

6. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

6.1 Compliance with CQC Registration Requirements, including Mental Health Act visit feedback summary report.

1. There has been no formal report issued following the CQC compliance inspection at Bootham Park, however there had been concerns identified around safety and environmental issues and patients had subsequently been moved to other Hospitals.
2. The formal agreement from the CQC had been received to register application for 7 services in the Vale of York, (except Bootham Park).

3. The report included a Mental Health Act Bulletin setting out specific topics around physical healthcare, medicines management and bed management.
4. There were ongoing CQC regulation breaches in connection with mixed sex accommodation at Acomb Garth, AMH rehabilitation Ward in York and Selby. Plans were in place to address these environmental issues, which also included ligature points.
5. It was noted that there had been some excellent feedback in recent MHA reports and staff should to be commended on their hard work.

6.2 WORKFORCE STAFFING REPORT – RECRUITMENT & RETENTION

1. The number of newly qualified registered nurses appointed in the reporting period had fallen by 31% and further work would be undertaken to understand the impact of this on services.
2. A nurse recruitment plan for York services would be developed following the transfer of these services to TEWV.
3. A publication 'Mind the Gap' highlighted the expectations of new nurses and the Trust would need to respond to these in order to recruit and retain nurses in the future.
4. It was clear that nurses expected more work life balance, with job sharing and flexible working and at the present time 30% of the Trust workforce was working part time hours.
5. A centralised recruitment process would enable the Trust to appoint suitable people that had previously been interviewed but were unsuccessful by holding them on a list. This would avoid unnecessary re-advertising and speed up the process.

7. IMPLICATIONS/RISKS

7.1 Quality

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

7.2 Financial

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

7.3 Legal and Constitutional

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

7.4 Equality and Diversity

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

8. CONCLUSIONS

The Quality Assurance Committee received and approved all the corporate assurance and performance reports that were considered.

All risks highlighted were being addressed with proposed mitigation plans or where they were currently being managed, additional information and assurances were requested.

9. RECOMMENDATIONS

That the Board of Directors note the issues raised at the QuAC meeting and the confirmed minutes of the meeting held on 3 September 2015, (appendix 1).

Richard Simpson, Non-Executive Director (Acting Chairman of QuAC)

Appendix 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 3 SEPTEMBER 2015, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2PM

Present:
Dr Hugh Griffiths, Non-Executive Director, (Chairman)
Mrs Lesley Bessant, Chairman of the Trust
Mr Brent Kilmurray, Chief Operating Officer
Mrs Elizabeth Moody, Director of Nursing & Governance, (for minute 15/149)
Mr Jim Tucker, Non-Executive Director
Mr David Jennings, Non-Executive Director

In attendance:
Mrs Karen Agar, Associate Director of Nursing and Governance, (for minutes 15/146 & 15/147)
Mr Levi Buckley, Director of Operations, Forensic Services
Mrs Adele Coulthard, Director of Operations, North Yorkshire
Mrs Jennifer Illingworth, Director of Quality Governance, (for minutes 15/140-143 and 15/148-152)
Mrs Donna Oliver, Deputy Trust Secretary
Mr Richard Morris, Deputy Head of Pharmacy, (for minute 15/154)
Mr Chris Lanigan, Head of Planning & Business Development, (for minutes 15/137, 15/138 & 15/139)
Mr Richard Simpson, Non-Executive Director

Andrew Ellis, Jacqueline Sibanda, Jessica Shaw, Wallis Stabler and Lianne Savage - Students, University of Teesside.

15/132 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Mr Martin Barkley, Chief Executive, Mrs Sharon Pickering, Director of Planning, Performance and Communications, Mr Chris Williams, Chief Pharmacist, Dr Neil Mayfield, Deputy Medical Director, Dr I Whitton, Deputy Medical Director, Ms Christine McCann, Associate Director of Nursing and Dr Nick Land, Medical Director.

15/133 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 2 July 2015 be approved and signed by the Chairman of the Committee.

15/134 ACTION LOG

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

The following updates were noted:

15/55 "Assurance measures and KPIs to be developed for the Physical Healthcare and Wellbeing report".
This report would be presented to the October 2015 QuAC meeting.

15/65 "KPIs from the Data Quality Assessment of the Quality Scorecard to be reported to QuAC".
This would be reported to the November 2015 QuAC meeting.

15/81 "Force Reduction Report to come to QuAC every 6 months starting from August 2015.
Due to late submission this report was deferred to the October 2015 QuAC meeting.

Action: Mr S Davison

15/97 "Risk registers to be attached to locality reports".

Completed

15/114 "Update to be provided to QuAC on discussions with other providers to check if the Trust is an outlier".
Since Dr Land was not present at the September QuAC meeting, this update would be brought back to the October 2015 QuAC meeting.

Action: Dr N Land

15/115 "All future reports to include top 3 concerns and assurances around these".
Authors reports would be informed of this requirement for QuAC.

Action: All

15/116 "Outcome of clinical audits to be circulated to locality leads".
Mrs Illingworth confirmed that the outcome of audits would be circulated in future.

Completed

15/117 "Future clinical effectiveness reports to include more information around levels of assurance as well as information".
This would be picked up in the October 2015 report to QuAC.

Action: Mrs J Illingworth

15/119 "Future Patient Safety Reports to give assurances around how lessons learned are translated into changed and sustainable practices".

Completed

15/120 "Consider whether the Patient Experience Group should meet bi-monthly, rather than monthly due to being inquorate".
Mrs Moody had discussed this with the Chairman of the Patient Experience Group and this meeting would move to bi-monthly.

Completed

15/124 "Patient Safety & Patient Experience Report – amendments as set out under minute 15/24".

Completed

15/125 "Quarterly report on Workforce staffing to come to QuAC, commencing with report on recruitment and retention".
This report would be presented to the October 2015 QuAC meeting.

Action: Mr D Levy

15/135 FORENSIC SERVICES LMGB ASSURANCE/INFORMATION REPORT

The Committee received and noted the Forensic Services LMGB Governance report.

Mr Buckley highlighted that the top 3 concerns at present were:

8. NHS England and the LD transformation programme, which allowed patients to move from non secure beds to the community and the intention to reduce LD beds by 50% over the next 2-3 years.

Discussions were underway on this matter at local and national level as there were concerns around clinical quality and business risks. Further discussion would go to the Board of Directors on 29 September 2015.

9. Staffing pressures and the levels of qualified cover between June – August 2015 in Forensic Learning Disabilities, as well as similar pressure on Forensic Mental Health.

Staff from day shifts had been utilised to cover night shifts and ultimately this had impacted on staff being able to take leave.

10. CQC inspection to FLD. Following a visit to FLD services in March 2014 there would be a further unannounced visit to review the evidence against the action plan.

Arising from the report it was noted that:

(1) Forensic Mental Health (FMH)

(a) A standard process had been approved for volunteers to work within FMH.

(b) There had been staffing issues, particularly for nights and weekends and there had been limited response from the bank.
This would be picked up with the bank coordinator.

(c) No new risks had been identified for the risk register.

On this matter it was noted that a new format report had been designed for the risk register and this would be featured in the next Forensic locality report in November 2015.

(2) Forensic Learning Disabilities (FLD)

(a) The staffing pressures had led to 8 shifts between June – August 2015 when a Ward did not have a registered member of staff. Ward managers had stayed late to cover medication rounds and other qualified staff had provided cross cover.

(b) The potential risk of the Transforming Care Agenda would be added to the risk register.

(c) Concerns were raised over the lack of seclusion suites available should an FLD patient require access to seclusion.

(3) Offender Health & Quality Assurance Group (OH & QuAG)

Recruitment to HMP Northumberland continued to be challenging and Commissioners had asked the Trust to consider recruitment premia as an incentive.

Following discussion it was noted that:

(i) There was an issue over the definition of a delayed discharge and how this was being interpreted by social workers. This would be discussed further with NHS England.
There were clear examples of patients who were ready for discharge, however there was no suitable placement for them within the community setting.

(ii) The staffing issues at present were due to problems with both recruitment and retention.
(iii) Out of 400 shifts over a period of 3 months, there had been 9 shifts affected in total.

On this matter it was noted that:

1. Following recent expansion of some services there had been some staff moving over to community jobs, rather than choosing to work night shifts.
2. Mrs Moody gave assurances that safe staffing levels were in place on the Wards with mitigating actions should there be further staff shortages.

15/136 NORTH YORKSHIRE LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the North Yorkshire Locality Governance Report.

Mrs Coulthard highlighted from the report:

(1) Adult Mental Health (AMH)
(a) The new Orchards rehabilitation facility in Ripon was now fully operational, following registration by the CQC and patients had been transferred from Abdale House on 4 August 2015.
(b) Plans and work had been agreed to address issues around privacy and dignity standards, following the CQC visit to Ward 15 at The Friarage Hospital.
(c) A business case had been developed at the request of North Yorkshire Police to create a NY wide Mental Health Triage Service. These plans would embed a Mental Health Nurse in the Police Force control room to provide direct advice, guidance and clinical triage for the Police Officers on the beat.

(2) Children & Young People's Services (CYPS Tier 3)
(a) There had been a significant increase in very complex cases referred to services and all
Agencies were involved in discussions around these children to ensure appropriate delivery of care. The impact of this increase had led to a back log of work over the summer 2015.
Work was underway with foster placements to try and prevent admission to Trust beds.
It was recognised that parents were struggling to cope with some of these complex children and their behavioural issues.
(b) Mrs Bessant expressed concern over the staffing problems and waiting times at Northallerton CAMHS and the quality of care offered to children in that area, causing North Yorkshire to be an outlier.

Agreed: that a report should be taken to the October 2015 Board of Directors meeting, setting out the commissioning issues and the impact on Children's services.
Action: Mrs A Coulthard

(3) Children & Young People's Services (CYPS Tier 4)
(a) West Lane (phase 3 building) was on schedule; however the building work had caused some challenges with health and safety issues. This would be monitored closely by the service.

(4) Learning Disabilities Services (LD)
(a) There was currently 1 candidate interested in the role to replace Clinical Director, Dr Whaley.

(b) The service support plan for Harrogate and Craven continued to be monitored through the QuAG and LMGB.

(5) MHSOP

Work had been agreed to upgrade Ward 14 at The Friarage Hospital to comply with eliminating mixed sex accommodation.

15/137 QUALITY STRAGEGY SCORECARD

The Committee received and noted the Quality Strategy Scorecard for Quarter 1 2015/16.

Mr Lanigan highlighted from the report the significant reds on the Trust Quality Strategy Scorecard, which were not achieving target, as set out in Appendix 3 of the report.

Arising from discussion it was noted that:

(a) The Committee did not feel assured on the key messages from the Scorecard and felt that there were a "lot of reds" to look through and intangible metrics.
(b) There would be a workshop held in October 2015 with Department Heads to look at the Quality metrics and scorecard, together with the targets. The outcome of this would be brought back to QuAC in December 2015.

Action: Mrs J Illingworth/Mrs S Pickering

15/138 QUALITY ACCOUNT Q1 PROGRESS REPORT

The Committee received and noted the Quality Account 2015/16, Quarter 1 progress report.

Mr Lanigan highlighted from the report:

(1) The performance against the quality metrics for the number of unexpected deaths classed as a serious incident per 10,000 open cases was 4.73, which was 1.73 above target. This related to 26 unexpected deaths during the quarter, 10 in Durham and Darlington, 8 in North Yorkshire and 8 in Teesside.

The number of unexpected deaths had risen compared to 2014/15 and some benchmarking would be undertaken to look at this.

(2) Patient falls per 1000 admissions for Quarter 1 was 34.66, which was 5.87% above target, however, this was significantly below the 2014/15 figure and meant there had been 53 falls during the quarter.

Agreed - that there should be some narrative around the indicator on patient falls to explain the actions that were being taken to improve this position.

Action: Mrs S Pickering

(3) Average length of stay for adult patients had remained steady and below target since Quarter 1 2014/15.

Arising from discussion it was noted that:

(a) Future reports should set out the key problems and exception areas, together with assurances around actions being taken to address these.
(b) The QuAC did not wish to receive Appendix 2 in future reports.
(c) Work was being undertaken to look at modelling for length of stay for older people and for the beds being built into the Harrogate inpatient provision.

15/139 QUALITY ACCOUNT STAKEHOLDER EVENT

The Committee considered and noted the report on the Quality Account Stakeholder event held in July 2015.

Arising from the report Mr Lanigan highlighted the quality improvement themes in section 5.1 had been identified from the work groups at the event. The Committee was asked to consider these for inclusion in the Quality Account for 2015/16.

Following discussion it was noted that:

(a) The Committee did not feel they could comment on any of the suggested improvement themes, identified by the work groups, except theme c) – 'Patient and Carer support through transitions from inpatient to community and full discharge: and/or CAMHS to AMH'.
(b) There had not been any CCG or Overview and Scrutiny members present at the workshop; however they had been invited to comment on the information.
(c) The Trust had a responsibility to work in partnership with other areas and recognise that some of the bigger issues could not be fixed in 1 year.

Agreed -

(i) That the current Quality Account be reviewed and look at what lessons could be learnt.
(ii) That the outcome of the Stakeholder Event be reflected back to the Health and Wellbeing boards and Overview and Scrutiny Committee.

Action: Mrs S Pickering

15/140 CLINICAL EFFECTIVENESS GROUP (CEG) ASSURANCE REPORT

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

Arising from the report it was highlighted that:

(1) The report included summaries for clinical audits.
(2) The MHSOP falls audit had been compliance rated red and review by the service had not been able to identify the root cause, however it was felt it had been attributable to either recording issues or the specialty being non-compliant with the pathway.
(3) The group had reviewed the Safety Thermometer findings for the previous 5 months and no significant issues had been identified.
(4) There had been updates from the NICE Physical Healthcare Group and it was noted that NICE had now been included in the Trust induction.
(5) At the July CEG meeting there had been discussion around an audit of POMH Topic 10c: use of antipsychotic medication in CAMHS.
There was further work to be done around improving practice standards and a further re-audit would be undertaken to monitor this.
(6) There would be a Trust wide event held on 27 September 2015 in relation to DNAs. This had been organised as a result of poor compliance to the DNA Policy Audit.

Agreed -

(a) That reports to QuAC, as well as the locality reports, should include a clear statement at the beginning of the report, outlining the top 3 concerns and exceptions, together with any assurances around actions being taken to address these. This would be part of an ongoing piece of work to improve and standardise reports to QuAC over the next few months.

(b) That the key messages be set out clearly in the appendices to the report.

Action: Mrs J Illingworth

15/141 PATIENT SAFETY GROUP ASSURANCE REPORT

The Committee received and noted the report of the Patient Safety Group for June 2015.

Mrs Illingworth drew attention to the following within the report:

(1) The outcome of the meetings of the Patient Safety Group in August and September 2015, would be reported to the October QuAC.
(2) There were ongoing concerns over the number of outstanding Datix – 96 at present, which were over 10 days and waiting for approval by a manager.
It was anticipated that the new central Datix team would make some improvements to the Datix system by October/November 2015.
(3) Plans for the Patient Safety Bulletin and lessons learned had been discussed at the EMT meeting on 2 September 2015 and it had been agreed that this would go to the Patient Safety Group at the end of September 2015. The Bulletin would share lessons learned from SUIs and there would be some new performance indicators for this group established in due course.

Agreed –

(i) That the terms of reference not be appended to this report in future.
(ii) That the 96 outstanding Datix be analysed further to provide some context and meaning to the data.

Action: Mrs J Illingworth

15/142 PATIENT EXPERIENCE GROUP ASSURANCE REPORT

The Committee received and noted the Patient Experience Group report.

Arising from the report it was noted that:

(1) The response around Friends and Family continued to improve, which demonstrated good practice.
(2) There had been a 5% increase in contact with PALs over the last Quarter with 268, compared to 256 for Quarter 4.
(3) There had been 54 complaints received between April to June 2015, which had all been investigated and responded to. 35 of those complaints had been received in AMH.

Agreed – that the spike in complaints received in AMH be analysed further to establish any specific trend.

Action: Mrs J Illingworth/Dr I Whitton

During discussion concerns were raised:

(a) Around the low levels of recording of whether patients had been offered a copy of their care plan.
This had been following a request that had been submitted to the CPA steering group.

(b) That there was a recurring theme from patients who had reported feeling unsafe, with 4 areas scoring below 90% and 2 areas that had not met the 90% overall rating for satisfaction. This would be discussed further with Modern Matrons and brought back to QuAC in November 2015.

Action: Dr A Khouja

15/143 CARER SUPPORT STRATEGY SCORECARD

The Committee considered the current Trust Carer Support Strategy and the proposal to develop a scorecard to monitor the strategy.

Arising from the report it was highlighted that:

(1) The aim of the strategy was to set out the Trust's commitment to improving the experience of carers and to support them for their recognised expertise and knowledge.
(2) A draft scorecard had been developed with the Patient Experience Group, which included measures around carer awareness and carer involvement.
(3) The QuAC were asked to approve the scorecard and consider whether a review of the carer support strategy was required.

Following discussion it was noted that:

(a) The Strategy had read more like a statement of intent and would require further work. The content and status of the Strategy would be discussed further outside the meeting.

Action: Mrs E Moody

(b) The use of a scorecard would not be the best tool for monitoring such a strategy and other outcome measures should be considered. Formal engagement around The Triangle of Care was currently on hold, however this would be re-visited.

15/144 INFECTION, PREVENTION AND CONTROL ASSURANCE REPORT

The Committee considered and noted the Infection, Prevention and Control Report for the period 1 April – 30 June 2015.

Arising from the report it was noted that:

(1) The report included audits across the localities showing returns on IPC Essential Steps to safe clean care reducing healthcare associated infections.
Improvements were underway on the collation of audits, which would be launched at a Champions Study event in November 2015.
(2) IPC nurses would carry out audits of those areas that had failed to submit their returns during 2015/16, new builds and any clinical area scoring less than 85% or 100%.

Some IPC Champions had been lost over the last 6 months due to staff movement; however efforts had been made to regain that communication with new Champions.

Following discussion it was noted that:

(a) There had been an outbreak of Diarrhoea & Vomiting at MHSOP Springwood and concerns were expressed around whether this correlated to the fact that audits had not been returned for those 2 months.
It was known that there had been an issue with staffing on this ward, however this would be checked.

Action: Mrs E Rolfe

15/145 PROCEDURES:

(i) MRSA – MANAGEMENT OF PATIENTS WITH MRSA

(ii) ACCIDENTAL INNOCULATION
(iii) OUTBREAK OF INFECTION

The Committee considered the procedures listed above, which had been submitted to QuAC for approval.

Following discussion it was noted that:

(1) Clinical Procedures should go through the Infection Prevention and Control Committee and then be formally approved at EMT, since it was not defined in the QuAC terms of reference to approve Trust Procedures.
(2) The Trust Policy: 'Policy & Procedures for the development of Policies, Procedures and Protocols' was currently under review, led by Mrs Jo Flintoff, Information, Risk and Policy Manager. It stated in the Policy that *"The Executive Management Team will ratify clinical policies, following approval by the Quality Assurance Committee".*

It was recognised that there needed to be clear definition around the approval process for each different matter, ie a clinical Policy, Procedure and Protocol.

Agreed – that there would be further discussion on the terms of reference of the QuAC around the approval of clinical policies.

Action: Dr H Griffiths/Mrs L Bessant

15/146 SAFEGUARDING CHILDREN ASSURANCE REPORT

Mrs Agar provided a verbal update on the safeguarding children issues:

(1) There were 3 serious case reviews in Redcar around sexual exploitation. The Trust was involved in 2 serious case reviews in Durham, one which was almost complete involving the crisis team and a young baby. There had been some lessons learnt from this incident around lack of communication with the Midwife/Health Visitor involved in the case.

(2) The incident in Hartlepool involving 2 young girls and a vulnerable adult had been delayed due to social media issues around the trial. The trial was planned to begin in February 2016 and would now take place in either Leeds or Newcastle.

(3) It was pleasing to note that level 3 safeguarding children training had increased to 72% for all areas across the Trust, which was an improvement from 63%.

15/147 SAFEGUARDING ADULTS ASSURANCE REPORT

Mrs Agar provided a verbal update on safeguarding adult issues:

(1) As mentioned previously the incident in Hartlepool involving a vulnerable adult had been delayed. This was a case involving a service user well known to the Trust and whilst this case would not go to adult review there had been some learning points for services.
(2) There had been a nasty incident in Brambling forensic services recently involving a scalding and blistering from hot tea, which had been thrown by a patient over someone. This incident had been reported to the police and adult safeguarding.

Following discussion it was noted that concerns had been raised at recent SUI panels that safeguarding issues were being missed by staff. The Committee asked for assurance to be given that this matter would be monitored closely in future.

15/148 QUARTERLY CLINICAL AUDIT AND EFFECTIVENESS REPORT

The Committee considered and noted the Quarterly Clinical Audit and Effectiveness Progress update report for Quarter 1.

Arising from the report it was noted that:

(1) There were 20 out of 161 planned clinical audits completed, (12.4%), which was an improvement of 8.7% on the position at the end of July 2014.
(2) There had been some new NICE guidance published during Quarter 1, which would be subject to implementation procedures. These were around quality standards, clinical guidelines and technology appraisal guidance.

Following discussion it was noted that there were a significantly high number of audits showing an amber status. This would be checked against the previous Quarter's results.

Action: Mrs J Illingworth

15/149 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

The Committee considered and noted the position of compliance with Care Quality Commission registration requirements.

Arising from the report it was highlighted that:

(1) Following a meeting on 31 July 2015 the Trust had submitted applications to register 8 locations in respect of the transfer of the Vale of York.
Bootham Park had been identified as non-compliant in respect of estate issues.
(2) The CQC had published a handbook on 31 July 2015 setting out plans to inspect health and social care in secure settings.
(3) The CQC had published the results of focussed inspections at South West London and St George's Mental Health Trust, which were Wards for older people with mental health problems and also Northamptonshire Healthcare NHS Foundation Trust. Improvements had been identified from these inspections.

Following discussion it was noted that there would be further debate around non-compliance at Bootham Park at a Board meeting in September 2015.

Action: Mr B Kilmurray

15/150 PATIENT SAFETY ANNUAL REPORT

The Committee received and noted the Patient Safety Annual Report.

From the report it was highlighted that:

(1) The major headlines outlined on page 3 of the report included some comparisons with 2013/14 and showed that there had been an increase of 7 SUIs in the year. The SUIs had been broken down by locality and by Directorate.
(2) There had been 2 homicides in the last year, (1 as a victim and the other a perpetrator) and no increase in the number of physical assaults in 2014/15, compared to 2013/14.

(3) The total number of incidents reported overall by the Trust had increased by over 100.
It was noted however that due to capacity issues the reporting of incidents varied between Wards.
(4) Adult Mental Health services – violence and aggression had decreased towards staff.
(5) MHSOP – violence and aggression had increased by almost 38% over a 4 year period.
(6) Learning Disability Services – had shown the highest reported incident category in the last 4 years, however violence and aggression towards staff had reduced by almost 50% over the last year.
(7) CYPS – had shown an increase of both medication incidents and violence and aggression towards staff, with the most significant incidents relating to self-harm. This was also the picture reflected nationally.
(8) Forensic Mental Health Services – there had been a decrease in violence and aggression towards staff, however an increase towards other patients, reflecting the complexity of the client group.

Following discussion it was noted that:

(1) The SUIs were difficult to interpret and future reporting should include a more meaningful denominator.
(2) There would be some further analysis undertaken to look into incident reporting, by obtaining some raw data and figures from NRLS to make some comparisons and report back to QuAC in December 2015.
(3) It would be useful to include some kind of benchmarking around incidents to give further assurance.
It was anticipated that the new centralised approval team, effective from 1 October 2015, would provide a more vigorous sensor check on incidents.

Action: Mrs J Illingworth

15/151 PATIENT SAFETY AND PATIENT EXPERIENCE REPORT

The Committee considered and noted the Patient Safety and Patient Experience Data report for the period 1 June – 31 July 2015.

Arising from discussion it was noted that:

(1) The Patient Safety and Patient Experience report would be presented to the Quality Assurance Committee on a quarterly basis, rather than monthly. The next report would be due in November 2016.
(2) Future reports should include analysis and narrative around exceptions and/or concerns, particularly when figures could be skewed and look disproportionately high when they referred to 1 patient and repeated episodes.

15/152 MENTAL HEALTH LEGISLATION CQC THEMES SUMMARY REPORT

The Committee considered and noted the CQC MHA visit feedback summary report for the period 1 April - 30 June 2015.

It was highlighted from the report that:

(1) There were minimal CQC MHA inspections during the quarter with none in April, 1 in May and 3 in June 2015.

It was felt that this was due in part to the ongoing CQC recruitment and it was anticipated that inspections would increase once all the Inspectors were in post from July 2015 onwards.
The Trust had received 2 out of the 4 reports so far and 9 areas had been identified with actions around them, which were being addressed.

(2) There would be further discussion around reporting lines and accountability to QuAC to ensure there was no duplication with the Mental Health Legislation Committee.

Action: Mrs E Moody/Mr R Simpson

15/153 INFORMATION STRATEGY AND GOVERNANCE ASSURANCE REPORT

This report was withdrawn from the agenda, pending discussions between Mrs Moody, Dr Griffiths and Mr Martin to look at what information was required in future by the QuAC, in accordance with the Committee's terms of reference.

Action: Mrs Moody/Dr Griffiths/Mr Martin

15/154 DRUG AND THERAPEUTICS (D&T) REPORT

The Committee considered and noted the Drug and Therapeutics Report for the period July – August 2015.

It was highlighted from the report:

(1) That the D&T Committee had discussed the delay in the project to integrate blood results onto Paris and the risks had been highlighted associated with prescribing when access to blood results was limited.
(2) Primary care colleagues had been unable to access the approved TEWV guidelines on the Trust website, due to website developments.
Guidelines were being shared as attachments.

Following discussion it was noted that there would be discussion at the next Drug and Therapeutics Committee around the potential move towards prescribing of E. Cigarettes and the financial impact this would have on the Trust.

15/155 EXTERNAL AGENCY VISITS, INSPECTIONS AND ACCREDITATIONS

The Committee considered and noted the Protocol: External Agency Visits, Inspections and Accreditations.

Since this Protocol had been approved by EMT it was not considered to be part of the remit of the Quality Assurance Committee to provide further approval.

15/156 QUARTERLY FORCE REDUCTION REPORT

This report had been deferred to the October 2015 QuAC meeting, due to late submission.

Action: Mrs D Oliver/Mr S Davison

15/157 EXCEPTION REPORTING (LMGBs, QAC sub groups)

There was nothing to note under this item.

15/158 ANY MATTERS ARISING TO BE ESCALATED TO THE BOARD OF DIRECTORS, AUDIT COMMITTEE, INVESTMENT COMMITTEE OR TO THE CLINICAL LEADERSHIP BOARD

There were no matters arising.

15/159 ANY OTHER BUSINESS

There was no other business to note.

15/160 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 1 October 2015,
2.00pm – 5.00pm in the Board Room, West Park Hospital.
Email to Donna Oliver donnaoliver1@nhs.net
The meeting concluded at 4.45pm

……..

Mr Richard Simpson
Acting Chairman
1 October 2015

Item 7

BOARD OF DIRECTORS

Date of Meeting: **Tuesday 27 October 2015**

Title: **To consider the "Hard Truths" monthly Nurse Staffing Update Report**

Lead Director: **Elizabeth Moody, Director of Nursing and Governance**

Report for: **Information and assurance**

This report includes/supports the following areas:

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

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

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

BOARD OF DIRECTORS EXECUTIVE SUMMARY

Date of Meeting: **Tuesday 27 October 2016 – referring to September 2015 data**

Title: **To consider the "Hard Truths" monthly Nurse Staffing Update Report**

1. Introduction

To advise the Board of the monthly information on nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to September 2015 data.

2. Summary of Key Issues

- There was an improvement across all indicators in relation to the month on month trend with all showing as 'green'.
- The number of wards showing as 'red' has decreased this month to 43 from 49.
- Durham & Darlington have the lowest number of red wards. Forensic services have the highest number of red wards although this has reduced this month.
- The lowest fill rate is in relation to Oak Ward, this is due to 3 staff on long term sick and another on maternity leave. The second lowest fill rate was in relation to Cedar (NY), this is due to an incorrect HealthRoster template being used. Cedar (NY) was highlighted in last month's report as having a low staffing fill rate.
- Westerdale South has the highest fill rates within the trust during this reporting period. This highlights that they are working above their budgeted establishments due to an agreed overspend by EMT due to the complexities of the current patient group.
- Bank usage as a percentage of total hours worked for Westerdale South was 75% within the reporting period. Westerdale South has featured as the highest user of bank for the last 3 months. Merlin is reporting as having the second highest at 61%.
- Agency usage has increased this month but this only equates to 0.50% of the total hours worked.
- In terms of the triangulation of relevant information:
    - Cedar (NY) who had the lowest staffing fill rate also had a level 3 incident and a PALS related issue during the reporting period.
    - Westerdale South who has high staffing fill rates also had a complaint and a PALS related issue raised during September 2015.
    - Westwood Centre was also highlighted as having a high fill rate; they also had a level 3 incident and were highlighted as having the highest number of incidents requiring control and restraint.

3. Significant Risk

The report and triangulation of staffing and quality data has been considered at the Operational Management Team and by the Director of Nursing and Governance. No direct risks or implications to patient safety or experience have been identified within the reporting period.

4. Recommendations

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

Emma Haimes
Head of Quality Data

Date of Meeting: **Tuesday 27 October 2016 – referring to September 2015 data**

Title: **To consider the "Hard Truths" monthly Nurse Staffing Update Report**

1. INTRODUCTION AND PURPOSE

1.1 To advise the Board of the monthly information on nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to September 2015 data.

2. BACKGROUND

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

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

Work continues to rationalise the report to ensure that the monthly report focusses exclusively on providing assurance that the staffing levels were safe.

A solution is being sought to ensure that the Trust are able to incorporate the York and Selby locality into the report from next month.

3. KEY ISSUES

3.1 Safe Staffing Fill Rates

3.1.1 The daily nurse staffing information aggregated for the month of September 2015 is presented in Appendix 1 and 2, with locality information in Appendix 3.

The total number of inpatient rosters during the month of September 2015 equates to 65 and remains unchanged from the previous month.

Abdale House moved into The Orchard on the 3rd August 2015 however, the electronic roster has not been amended to reflect this change therefore throughout this report the unit will be referred to as Abdale House.

3.1.2 The month on month trend report shows a significant improvement with all metrics for both staff groups showing 'green' when compared to the previous month:

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
Aug-15	87.90	↓	112.60	↓	98.10	↓	110.10	↓
Sep-15	90.3	↑	113.6	↑	98.20	↑	112.6	↑

The position in September was that there were 43 wards who had fill rates of less than 89.9% (shown as red) across both staff groups for all shifts. This is an improvement on the previous month as illustrated below:

Month	Sept	August	July	June	May	April
No. of Red Wards	43	49	41	38	36	33

The majority of the red wards fall into the Registered Nurse on Day shifts category where there were 33 wards shown as red in September compared to 36 in August 2015.

3.1.3 An improvement can be observed across all localities with the trend on previous month showing 'green'. The forensic services have the highest number of red wards with 20 during the reporting period which was an improvement on the previous month whereby there was 24. The table below shows the split across all localities over the last 6 months with the full detail available in appendix 3 of this report:

Locality	Number of wards red across all metrics						Trend on previous month
	Sept-15	Aug-15	Jul-15	Jun-15	May-15	Apr-15	
Durham and Darlington	5	6	3	3	3	2	↓
Teesside	8	9	10	6	6	6	↓
North Yorkshire	10	10	11	8	7	6	↔
Forensics	20	24	17	21	20	20	↓

3.1.4 The lowest staffing fill rate relates to Oak Ward which has replaced Cedar (NY). Oak Ward are reporting 46.8% for Registered Nurse on Day Shifts during September. The breakdown over the last 6 months is as follows:

	Sep-15	Aug-15	Jul-15	Jun-15	May-15	Apr-15
Oak Ward	46.8%	75.9%	85.0%	79.8%	95.2%	99.2%

The ward has articulated that the low fill rate was in relation to 3 members of staff being on long term sick with another on maternity leave. Shifts have been covered utilising bank, community staff and overtime.

The second lowest fill rate relates to Cedar (NY) for Registered Nurse on Nights which has declined to 47.8% in September compared to 54.2% in August as outlined below:

	Sept-15	Aug-15	Jul-15	Jun-15	May-15	Apr-15
Cedar (NY)	47.8%	54.2%	48.0%	106.9%	115.8%	103.3%

The ward has articulated that the low fill rate was in relation to 1 qualified only working a night duty and the electronic roster is currently set up for 2 RN's to work nights. The HCA fill rate for days (189.9%) would suggest that they have flexed the staff to cover the shortfall.

The third lowest fill rate relates to Overdale (RN on Day Shifts) which is reporting at 61.3% which is a decrease on the previous month whereby this was reporting at 68.8%. The 6 month trend for Overdale is as follows:

	Sept-15	Aug-15	Jul-15	Jun-15	May-15	Apr-15
Overdale	61.3%	68.0%	68.2%	79.7%	58.4%	73.2%

The ward has articulated that the low fill rate was in relation to 3 RN vacancies. It is evident that they have flexed their staffing to cover the shortfall (HCA fill rate for days equates to 145.3%).

There were 5 other wards that had low fill rates between 62.6% and 71.8%%, interestingly all of these were in relation to RN Day Shifts as articulated below:

	Sept-15	Aug-15	Jul-15	Jun-15	May-15	Apr-15
Newberry Centre	62.6%	76.0%	70.2%	81.6%	87.1%	89.7%
Ward 15	65.1%	77.6%	75.2%	81.0%	66.2%	80.4%
Brambling	67.9%	75.1%	78.7%	79.6%	94.6%	79.3%
Bransdale	68.6%	69.3%	63.7%	69.9%	78.5%	92.6%
Bedale	71.8%	78.1%	71.6%	82.9%	97.0%	82.3%

3.1.5 It is also important to review the fill rates that exceed their budgeted establishment (shown in blue). During the month of September there were 39 of the fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues. This is an increase when compared to August where there were 34.

Westerdale South saw the highest fill rate indicators during the month of September (290.6% and 207.3%) which was the second month running as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Westerdale South	101.5%	290.6%	100.3%	207.3%

The ward has reported that that the excess was used following an agreed overspend by EMT due to the complexities of the current patient group and increased HCA usage due to 2-3 patients being nursed on enhanced observations.

The second highest fill rate indicator was Merlin ward with 216.0% as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Merlin	104.6%	152.4%	77.1%	216.0%

Feedback from the ward has highlighted that they have flexed their staffing between registered and unregistered staff; this is evident when looking at the fill rates. In addition they have advised that the additional staffing was in relation to enhanced observations, escort and high acuity on the ward.

Westwood Centre had the third highest fill rate of 187.3% during the reporting period as follows:

Ward	Day		Night	
	Fill Rate – Registered	Fill Rate – Unregistered	Fill Rate – Registered	Fill Rate – Unregistered
Westwood Centre	101.4%	119.0%	104.9%	187.3%

Westwood has advised that the blue metric are reflective of the ongoing level of enhanced observations, patient transfers, outpatient appointments and increased acuity on the ward.

From those wards that had blue fill rate indicators during the reporting period the majority were for unregistered day shifts.

3.1.6 Appendix 6 highlights the usage of Bank Staffing, as a proportion of actual hours. These are 'RAG' rated independently of the overall fill rate. Those wards using greater than 50% bank staffing to deliver their fill rates are identified below:

Locality	Ward	Bank Usage	Comments
Teesside	Westerdale South	75%	The ward has been the highest user of bank for the last 3 months (73% in July and 74% in August)
Forensic Services	Merlin	61%	The ward has been the second highest user of bank for the last 2 months (46% in July and 66% in August)
Durham & Darlington	Maple Ward	50%	Increase on previous month whereby they were reporting as 45%

45 wards were reported as Amber (between 10 and 40%), which is a decrease on the previous month of August (47 wards).

From those wards highlighted this month as the biggest users of bank, the month on month trend is identified as follows:

	September	August	July	June	May	April
Westerdale South	75%	74%	73%	50%	45%	51%

Merlin	61%	66%	46%	28%	43%	36%
Maple Ward	50%	45%	45%	43%	28%	24%

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. There is work ongoing to ensure all bank workers have had the required competencies assessed and passed.

3.1.7 When considering staffing levels it is also important to consider the amount of agency worked within the reporting period. During September there was a total of 205,013.30 hours worked across the trust of which 1,034.27 were agency hours, equating to 0.50% of the total hours worked. The table below shows the breakdown of agency hours worked by locality and ward:

Locality	Ward	Total Agency Hours	Reason for using Agency
North Yorkshire	Cedar (NY)	368.00	Service Need
North Yorkshire	Springwood	304.00	Enhanced Observations and Annual Leave
North Yorkshire	Rowan Ward	293.77	Sickness and Enhanced Observations
Teesside	Westerdale South	46.00	Service Need
North Yorkshire	Ward 14	22.50	Maternity

This can be further correlated when compared to the total hours worked and the split between bank, agency and substantive workforce:

Ward	Total hours worked	Substantive Workforce	Bank	Agency
Cedar (NY)	4104.92	2752.17 (67%)	985 (24%)	368 (9%)
Springwood	3174.70	2364.45 (74%)	506 (16%)	304 (10%)
Rowan Ward	3097.50	2467.73 (80%)	336 (11%)	293.8 (9%)
Westerdale South	4462.90	1222.37 (27%)	3195 (72%)	46.0 (1%)
Ward 14	2377.92	2300.67 (97%)	54.80 (2.3%)	22.5 (1%)

It is positive to note that the agency numbers are extremely low within the Trust, it is important to continue monitoring this on an ongoing basis due to the potential risks that high agency working has on clinical areas

3.1.8 The quality metrics have been included within the appendices of this report. The triangulation of the staffing data against a range of quality metrics has been considered and the following is of relevance:

- One SUI occurred within the reporting period. This related to a ward that doesn't feature in this report as a result of a high or low fill rate, bank or agency usage.

- Three level 3 incidents occurred during September. No level four incidents occurred. The level 3 incidents occurred within a range of wards. 1 of the incidents occurred on Cedar (NY) which was highlighted as having a low staffing fill rate and agency usage. The other incident related to Westwood Centre which was highlighted as having a high fill rate.
- There were 3 complaints that occurred within the reporting period of which 1 related to Westerdale South which was identified within this report as having a high fill rate, agency and bank usage.
- There were 32 PALS related issues raised during September of which 1 related to Cedar (NY) which was identified within this report as having a low staffing fill rate, agency usage and a level 3 incident. There was 1 further PALS related issue which was relating to Westerdale South, this ward was highlighted within this report as having a high fill rate, agency and bank usage.
- A number of incidents requiring control and restraint occurred during the reporting period. The highest user was the Westwood Centre with a total of 134 incidents requiring control and restraint (5 of which required the use of Prone restraint), Westwood Centre was highlighted earlier in this report as having used a high staffing fill rate and a level 3 incident. All other incidents of control and restraint related to areas that have not been highlighted within this report.

For assurance purposes the Director of Nursing and Governance has requested further information in relation to incidents, complaints or PALS as above and has found no direct risks or implications to patient safety or experience as a result of staffing levels.

3.1.9 Although the Board did not agree to a dedicated Safe Staffing project for this year's Annual Plan (2015/16), this piece of work will be managed under business as usual with the following key objectives:

- To test out NHS England evidence based staffing framework and tools for MH wards in agreed in-patient areas including direct and non-direct patient care time.
- To ensure above indicators are compliant with emerging NICE guidance or other DH documentation
- To put in place Triangulation and hot spot systems for predicting planned requirements
- To implement regular reporting and monitoring systems within services to enable timely and informed intervention to occur

The output from the project will have a bearing on the format and quality of reports ultimately received by Board on this issue.

Work is on-going to review the process of validation and the use of quantitative and 'soft' information that provides context which is being sought from the wards currently as a manual process. Any information collected is retained within the department for reference, outliers are be followed up and consideration is being given as to how best to use this information to present it in a more meaningful summary for future reports.

3.1.10 On the 13th October 2015, a joint letter was sent to provider organisations from the Chief Nursing Officer (CNO), NHS Improvement, CQC and NHSE

This detailed

- Progress on the Model Hospital led by Lord Carter, who will be working with providers to develop a way to use data on nursing and care hours per patient, so that staffing arrangements remain safe across a range of different times and situations. A number of tools have been suggested for use by the CNO to produce data that is required to be included in the six monthly Board reports to demonstrate contact time. These will be explored as part of the Safe Staffing review.

- Confirmation that the development of further safe staffing guidance would be coming in due course.

- The mandatory use of approved frameworks for procuring nursing agency staff that came into effect from 19 October and plans to introduce a national rate-cap for all agency staff, to include medical and other agency staff later this autumn.

- The message that safe staffing guidance should support but not replace the judgements made by experienced professionals at the front line, reinforcing that responsibility for both safe staffing and efficiency ultimately rests with provider Boards.

4. IMPLICATIONS / RISKS:

4.1 Quality: No direct risks or implications to patient safety from the staffing data have been identified this month, although the following is of relevance:

- There was an improvement across all indicators in relation to the month on month trend with all showing as ‘green’.
- The number of wards showing as ‘red’ has decreased this month to 43 from 49.
- Durham & Darlington have the lowest number of red wards. Forensic services have the highest number of red wards although this has reduced this month.
- The lowest fill rate is in relation to Oak Ward, this is due to 3 on long term sick and another on maternity leave. The second lowest fill rate was in relation to Cedar (NY), this is due to an incorrect HealthRoster template being used. Cedar (NY) was highlighted in last month’s report as having a low staffing fill rate.
- Westerdale South has the highest fill rates within the trust during this reporting period. This highlights that they are working above their budgeted establishments due to an agreed overspend by EMT due to the complexities of the current patient group.
- Bank usage as a percentage of total hours worked for Westerdale South was 75% within the reporting period. Westerdale South has featured as the highest user of bank for the last 3 months. Merlin is reporting as having the second highest at 61%.

- Agency usage has increased this month but this only equates to 0.50% of the total hours worked.
- In terms of the triangulation:
    - Cedar (NY) who had the lowest staffing fill rate also had a level 3 incident and a PALS related issue during the reporting period.
    - Westerdale South who has high staffing fill rates also had a complaint and a PALS related issue raised during September 2015.
    - Westwood Centre was also highlighted as having a high fill rate, they also had a level 3 incident and were highlighted as having the highest number of incidents requiring control and restraint.

4.2 Financial: It has been identified that there is little spare capacity in nursing establishments as they have been planned for maximum efficiency – it is therefore implied that the workforce deployment needs closer scrutiny to ensure those efficiencies do not constitute risks. This work is being progressed and will be a feature of next financial years Safe Staffing project referred to above

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

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 Risks: The current lack of an evidence based tool for workforce planning and monitoring in mental health and learning disability nursing increases the risk that the publication of the workforce data will be compared to other Trust's data without appreciation of context. Information published on the Trust website will assist with provision of contextual information. NICE are expected to publish further guidance on evidence based approaches to staffing by the end of this year 2015

5. CONCLUSIONS

5.1 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.

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

5.2 It is difficult to draw any meaningful conclusions from the data presented within this report.

6. RECOMMENDATION

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

Emma Haimes
Head of Quality Data
October 2015

Appendix 1

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 30 DAYS IN September

				DAY		NIGHT	
WARD	Locality	Speciality	Bed Numbers	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)
Abdale House	North Yorkshire	Adults	9	161.6%	84.7%	120.0%	183.2%
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	13	94.1%	103.8%	112.6%	93.8%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	13	91.9%	106.9%	100.0%	98.4%
Bedale Ward	Teesside	Adults	10	71.8%	172.2%	101.4%	120.0%
Bilsdale Ward	Teesside	Adults	14	81.6%	121.3%	93.9%	103.4%
Birch Ward	Durham & Darlington	Adults	15	117.3%	108.5%	100.0%	100.0%
Bransdale Ward	Teesside	Adults	14	68.6%	139.1%	77.0%	112.0%
Cedar Ward	Durham & Darlington	Adults	10	110.0%	179.1%	100.0%	135.2%
Cedar Ward (NY)	North Yorkshire	Adults	18	92.8%	170.9%	47.8%	189.9%
Earlston House	Durham & Darlington	Adults	15	99.7%	103.3%	103.1%	101.5%
Elm Ward	Durham & Darlington	Adults	20	101.0%	146.9%	100.0%	141.7%
Farnham Ward	Durham & Darlington	Adults	20	106.6%	113.2%	100.0%	100.0%
Lincoln Ward	Teesside	Adults	20	105.8%	95.6%	103.1%	112.0%
Lustrum Vale	Teesside	Adults	20	98.0%	99.7%	108.7%	100.0%
Maple Ward	Durham & Darlington	Adults	17	91.8%	128.6%	100.0%	158.3%
Overdale Ward	Teesside	Adults	18	61.3%	145.3%	93.6%	106.7%
Park House	Teesside	Adults	14	95.9%	105.6%	100.3%	101.7%

Primrose Lodge	Durham & Darlington	Adults	15	90.0%	96.0%	106.7%	96.7%
Stockdale Ward	Teesside	Adults	18	79.9%	128.1%	101.7%	111.0%
Tunstall Ward	Durham & Darlington	Adults	20	94.8%	110.7%	96.7%	106.7%
Ward 15 Friarage	North Yorkshire	Adults	14	65.1%	137.5%	100.6%	113.3%
Willow Ward	Durham & Darlington	Adults	15	74.9%	167.4%	100.0%	135.0%
Baysdale	Teesside	CYPS	6	137.4%	93.9%	101.0%	100.0%
Holly Unit	Durham & Darlington	CYPS	4	115.4%	116.6%	100.0%	100.0%
Newberry Centre	North Yorkshire	CYPS	14	62.6%	106.2%	81.4%	84.2%
The Evergreen Centre	North Yorkshire	CYPS	12	96.7%	123.7%	108.1%	99.2%
Westwood Centre	North Yorkshire	CYPS	12	101.4%	119.0%	104.9%	187.3%
Clover/Ivy	Forensics	Forensics LD	12	90.4%	102.6%	100.0%	97.5%
Eagle/Osprey	Forensics	Forensics LD	10	95.9%	94.3%	103.3%	93.3%
Harrier/Hawk	Forensics	Forensics LD	10	76.8%	105.9%	99.5%	99.0%
Kestrel/Kite	Forensics	Forensics LD	16	79.0%	89.7%	96.7%	98.9%
Kingfisher/Heron/Robin	Forensics	Forensics LD	14	80.9%	91.6%	99.3%	92.1%
Langley Ward	Forensics	Forensics LD	10	88.2%	91.7%	107.0%	107.0%
Northdale Centre	Forensics	Forensics LD	6	83.5%	92.3%	103.9%	94.2%
Oakwood	Forensics	Forensics LD	8	90.2%	77.6%	100.0%	100.0%
Thistle Ward	Forensics	Forensics LD	5	75.2%	104.1%	90.0%	97.2%
Brambling Ward	Forensics	Forensics MH	13	67.9%	133.7%	103.4%	110.0%
Fulmar Ward.	Forensics	Forensics MH	12	83.1%	101.1%	101.5%	101.8%
Jay Ward	Forensics	Forensics MH	5	80.2%	108.9%	107.6%	106.7%
Kirkdale Ward	Forensics	Forensics MH	16	88.7%	105.7%	104.8%	120.0%
Lark	Forensics	Forensics MH	15	81.1%	110.0%	100.9%	98.3%

Linnet Ward	Forensics	Forensics MH	17	89.5%	113.8%	93.9%	96.7%
Mallard Ward	Forensics	Forensics MH	16	89.8%	123.3%	100.9%	133.7%
Mandarin	Forensics	Forensics MH	16	89.7%	101.4%	103.9%	100.0%
Merlin	Forensics	Forensics MH	10	104.6%	152.4%	77.1%	216.0%
Newtondale Ward	Forensics	Forensics MH	20	92.2%	102.4%	88.8%	106.9%
Nightingale Ward	Forensics	Forensics MH	16	88.2%	100.5%	100.6%	96.7%
Sandpiper Ward	Forensics	Forensics MH	8	103.4%	117.5%	94.9%	164.0%
Swift Ward	Forensics	Forensics MH	10	81.2%	110.8%	95.1%	102.0%
Aysgarth	Teesside	LD	6	108.3%	139.4%	100.3%	100.1%
Bankfields Court Unit 2	Teesside	LD	5	128.6%	100.9%	100.7%	110.6%
Bankfields Court	Teesside	LD	12	82.7%	113.8%	97.4%	102.0%
Bek, Ramsey, Talbot Wards	Durham & Darlington	LD	16	108.8%	98.0%	100.0%	104.1%
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	89.6%	148.8%	100.4%	100.0%
Hamsterley Ward	Durham & Darlington	MHSOP	10	82.5%	136.5%	100.0%	101.7%
Oak Ward	Durham & Darlington	MHSOP	12	46.8%	94.3%	96.7%	100.0%
Picktree Ward.	Durham & Darlington	MHSOP	10	93.9%	115.0%	100.0%	103.0%
Roseberry Wards	Durham & Darlington	MHSOP	15	100.0%	94.4%	100.0%	100.0%
Rowan Lea	North Yorkshire	MHSOP	20	86.3%	106.6%	102.8%	103.8%
Rowan Ward	North Yorkshire	MHSOP	12	114.3%	87.3%	119.7%	116.1%
Springwood Community Unit	North Yorkshire	MHSOP	14	81.2%	126.7%	100.0%	135.1%
Ward 14	North Yorkshire	MHSOP	9	85.0%	117.4%	106.7%	100.0%
Westerdale North	Teesside	MHSOP	18	96.9%	127.7%	100.3%	101.9%
Westerdale South	Teesside	MHSOP	14	101.5%	290.6%	100.3%	207.3%
Wingfield Ward	Teesside	MHSOP	9	85.1%	98.1%	100.0%	100.0%

Appendix 2

September	TRUSTWIDE DAILY POSITION –all wards	
	Difference between what was planned on roster and actually worked – RNs	Difference between what was planned on roster and actually worked – HCAs
1	-7%	12%
2	-6%	9%
3	-8%	13%
4	-9%	10%
5	-15%	15%
6	-6%	13%
7	-12%	15%
8	-5%	14%
9	-11%	14%
10	-6%	10%
11	-7%	9%
12	-5%	13%
13	-9%	16%
14	-9%	12%
15	-10%	14%
16	-6%	13%
17	-5%	12%

18	-9%	12%
19	-7%	11%
20	-4%	14%
21	-6%	11%
22	-6%	15%
23	-9%	15%
24	-7%	14%
25	-9%	14%
26	-7%	17%
27	-7%	18%
28	-4%	13%
29	-6%	13%
30	-4%	13%
31	0%	0%

Appendix 3

DURHAM & DARLINGTON LOCALITY REPORT - September 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Birch Ward	15	825	360	1044	720	968	360	1132.5	720	117.3%	100.0%	108.5%	100.0%
Elm Ward	20	858	360	702.66	720	866.34	360	1032	1020	101.0%	100.0%	146.9%	141.7%
Maple Ward	17	876.17	360	714	720	804.56	360	918	1140	91.8%	100.0%	128.6%	158.3%
Farnham Ward	20	843	360	701.33	720	898.66	360	794	720	106.6%	100.0%	113.2%	100.0%
Tunstall Ward	20	877	360	712.67	720	831.5	348	789.17	768	94.8%	96.7%	110.7%	106.7%
Willow Ward	15	863.17	360	720	720	646.5	360	1205.33	972	74.9%	100.0%	167.4%	135.0%
Earlston House	15	868.5	360	667.5	708	865.83	371.33	689.32	718.83	99.7%	103.1%	103.3%	101.5%
Primrose Lodge	15	861	360	684	720	774.66	384	656.33	696	90.0%	106.7%	96.0%	96.7%
Holly Unit	4	389.18	209	508.6	209	449.14	209	592.99	209	115.4%	100.0%	116.6%	100.0%
Cedar Ward PICU	10	816.5	360	660	1056	898.5	360	1181.76	1428	110.0%	100.0%	179.1%	135.2%
Ceddesfeld Ward	10	885	360	525	720	792.67	361.5	781.33	720	89.6%	100.4%	148.8%	100.0%
Roseberry Wards	15	885	360	774	720	884.66	360	730.34	720	100.0%	100.0%	94.4%	100.0%

Oak Ward	12	880.01	360	720	720	412.21	348	679.3	720	46.8%	96.7%	94.3%	100.0%
Picktree Ward.	10	885	360	646	708	830.67	360	743.16	729.33	93.9%	100.0%	115.0%	103.0%
Hamsterley Ward	10	885	360	525	720	730	360	716.6	732	82.5%	100.0%	136.5%	101.7%
Bek, Ramsey, Talbot Wards	16	859.75	360	3180	1776	935.5	360	3117.17	1848	108.8%	100.0%	98.0%	104.1%

FORENSICS LOCALITY REPORT - September 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Lark	15	836.12	337.5	1003.1	675	677.87	340.5	1103.25	663.75	81.1%	100.9%	110.0%	98.3%
Brambling Ward	13	836.75	337.5	923	675	568	349	1233.75	742.5	67.9%	103.4%	133.7%	110.0%
Fulmar Ward.	12	840	337.5	1260	675	697.75	342.5	1274.05	687.25	83.1%	101.5%	101.1%	101.8%
Jay Ward	5	836.43	337.5	1090	675	671.05	363	1186.5	720	80.2%	107.6%	108.9%	106.7%
Kirkdale Ward	16	747.18	337.5	1254.68	675	662.8	353.75	1326.3	810	88.7%	104.8%	105.7%	120.0%
Linnet Ward	17	835.75	337.5	983	675	747.8	317	1118.45	652.5	89.5%	93.9%	113.8%	96.7%
Mallard Ward	16	831.75	337.5	1258.5	675	747.09	340.5	1551.5	902.5	89.8%	100.9%	123.3%	133.7%
Mandarin	16	835	337.5	998.55	675	749.25	350.75	1012.75	675	89.7%	103.9%	101.4%	100.0%
Merlin	10	838	675	1000.25	675	876.17	520.5	1524.75	1457.75	104.6%	77.1%	152.4%	216.0%
Newtondale Ward	20	782.75	667.98	1511.75	663.75	721.37	593.23	1548.33	709.75	92.2%	88.8%	102.4%	106.9%
Nightingale Ward	16	824.25	337.5	971.87	675	727.25	339.5	977.2	652.5	88.2%	100.6%	100.5%	96.7%

Sandpiper Ward	8	835.12	675	1569.5	675	863.62	640.5	1844.25	1106.75	103.4%	94.9%	117.5%	164.0%
Swift Ward	10	839.3	337.5	1260	675	681.55	321	1396	688.25	81.2%	95.1%	110.8%	102.0%
Clover/Ivy	12	754	337.5	2019.77	1012.5	681.33	337.5	2072.94	986.75	90.4%	100.0%	102.6%	97.5%
Eagle/Osprey	10	837.5	337.5	1700.18	1012.5	802.8	348.75	1603.25	945	95.9%	103.3%	94.3%	93.3%
Harrier/Hawk	10	779.71	330.75	2023	1012.5	599.09	329	2141.92	1002.75	76.8%	99.5%	105.9%	99.0%
Kestrel/Kite	16	828.75	341	1995.34	1012.5	655.08	329.75	1789.59	1001.25	79.0%	96.7%	89.7%	98.9%
Kingfisher/Heron/Robin	14	803.65	337.5	1440.75	708.75	649.76	335.25	1319.54	652.5	80.9%	99.3%	91.6%	92.1%
Northdale Centre	6	829.5	337.5	2349.92	1350	692.83	350.5	2169.79	1271.25	83.5%	103.9%	92.3%	94.2%
Oakwood	8	824.75	337.5	675	337.5	744.25	337.5	523.5	337.5	90.2%	100.0%	77.6%	100.0%
Thistle Ward	5	784.13	337.25	1010.25	672.92	589.73	303.5	1051.42	653.92	75.2%	90.0%	104.1%	97.2%
Langley Ward	10	839.5	337.5	1012.5	337.5	740.51	361	928.33	361.25	88.2%	107.0%	91.7%	107.0%

NORTH YORKSHIRE LOCALITY REPORT - September 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Ayckbourn Unit Danby Ward	13	787.5	297.6	822	595.4	740.98	335.16	853	558.34	94.1%	112.6%	103.8%	93.8%
Ayckbourn Unit Esk Ward	13	962.5	297.6	826.48	594.4	885	297.6	883.73	585.01	91.9%	100.0%	106.9%	98.4%
Ward 15 Friarage	14	998.23	337.5	675	675	650	339.5	928	765	65.1%	100.6%	137.5%	113.3%
Cedar Ward (NY)	18	1043	645	938.5	645	967.75	308	1604.17	1225	92.8%	47.8%	170.9%	189.9%
Abdale House	9	585	345	450	345	945.5	414	381	632.18	161.6%	120.0%	84.7%	183.2%
Newberry Centre	14	1365.51	347.77	1288.67	704.2	855.47	282.97	1368.27	592.87	62.6%	81.4%	106.2%	84.2%
Westwood Centre	12	1280	494.5	1536	667	1298.25	518.5	1827.75	1249.5	101.4%	104.9%	119.0%	187.3%
The Evergreen Centre	12	1133.97	345	1345.6	691.65	1096.25	373	1664.25	686.15	96.7%	108.1%	123.7%	99.2%

Rowan Lea	20	976.15	360	1286.5	1080	842.33	370	1371.5	1121	86.3%	102.8%	106.6%	103.8%
Rowan Ward	12	1050	360	721.5	720	1200.5	431	630	836	114.3%	119.7%	87.3%	116.1%
Springwood Community Unit	14	967.5	337.5	900	675	785.34	337.5	1140.11	911.75	81.2%	100.0%	126.7%	135.1%
Ward 14	9	829.5	337.5	562.5	652.5	705.17	360	660.25	652.5	85.0%	106.7%	117.4%	100.0%

TEESSIDE LOCALITY REPORT - September 2015									AMH	CAMHS	PICU	MHSOP	LD
WARD	Bed Numbers	Planned RN - Days	Planned RN - Nights	Planned HCA - Days	Planned HCA - Nights	Actual Worked RN - Days	Actual Worked RN - Nights	Actual Worked HCA - Days	Actual Worked HCA - Nights	Fill Rate RN - Days	Fill Rate RN - Nights	Fill Rate - HCA Days	Fill Rate - HCA Nights
Bedale Ward	10	855	345	686.5	1035	613.5	350	1182	1242	71.8%	101.4%	172.2%	120.0%
Bilsdale Ward	14	813.5	347	677	678.5	664	326	821.5	701.5	81.6%	93.9%	121.3%	103.4%
Bransdale Ward	14	841.25	345	678.5	690	576.75	265.5	943.58	772.5	68.6%	77.0%	139.1%	112.0%
Lincoln Ward	20	840	375	1103	690	888.5	386.5	1053.98	772.5	105.8%	103.1%	95.6%	112.0%
Lustrum Vale	20	760.5	345	678.5	690	745	375	676.5	690	98.0%	108.7%	99.7%	100.0%
Overdale Ward	18	832.5	345	814	690	510.5	323	1183	736	61.3%	93.6%	145.3%	106.7%
Park House	14	653.5	345	670.7	690	626.7	346	708.5	701.5	95.9%	100.3%	105.6%	TEES
Stockdale Ward	18	825	345	847.5	655.5	659	351	1085.5	727.5	79.9%	101.7%	128.1%	111.0%
Baysdale	6	502.35	335.1	839.67	669.9	690.19	338.6	788.32	670.07	137.4%	101.0%	93.9%	100.0%

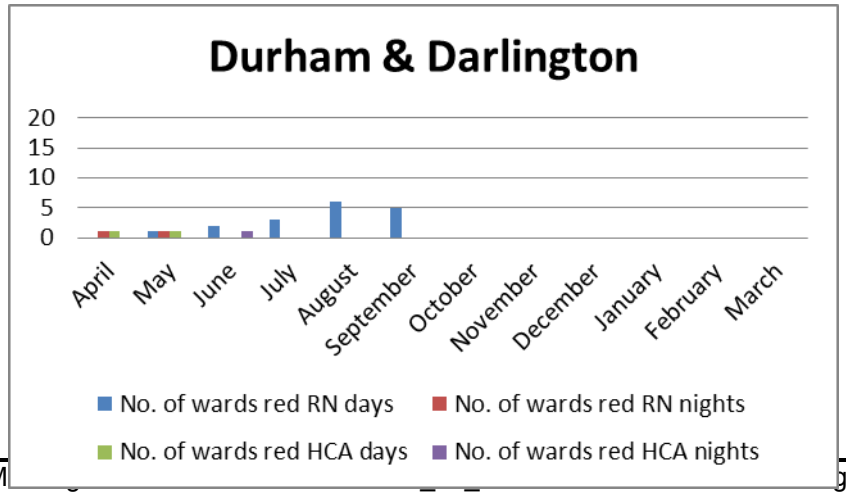
Westerdale North	18	832.5	345	678.5	667	806.5	346	866.5	679.5	**96.9%**	**100.3%**	**127.7%**	**101.9%**
Westerdale South	14	825	345	644.61	678.5	837	346	1873.4	1406.5	**101.5%**	**100.3%**	**290.6%**	**207.3%**
Wingfield Ward	9	784	375	586.5	690	667.5	375	575.5	690	**85.1%**	**100.0%**	**98.1%**	**100.0%**
Aysgarth	6	518	300	782.5	300	561.02	300.92	1091	300.25	**108.3%**	**100.3%**	**139.4%**	**100.1%**
Bankfields Court Unit 2	5	480.17	300.5	978.99	300	617.35	302.5	988.08	331.75	**128.6%**	**100.7%**	**100.9%**	**110.6%**
Bankfields Court	12	1392	708	3597.3	2152.58	1151.26	689.57	4093.68	2196.08	**82.7%**	**97.4%**	**113.8%**	**102.0%**

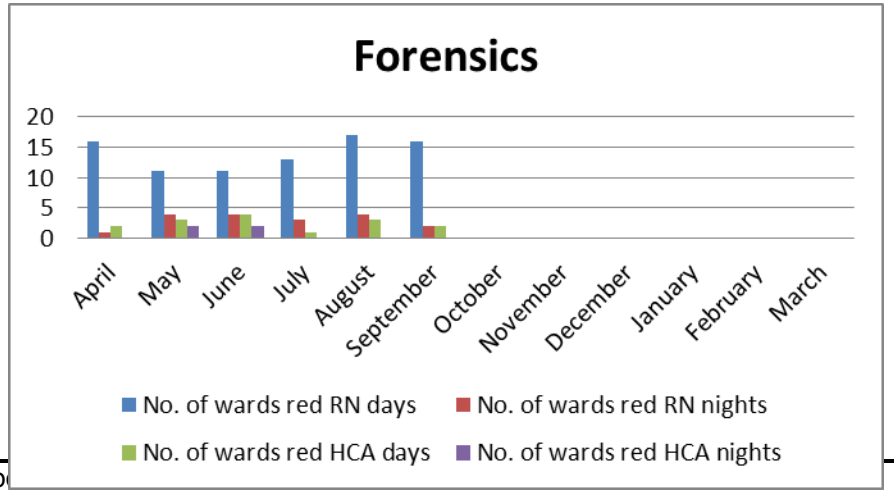
TEWV TOTAL - Month on Month Trend **Appendix 4**

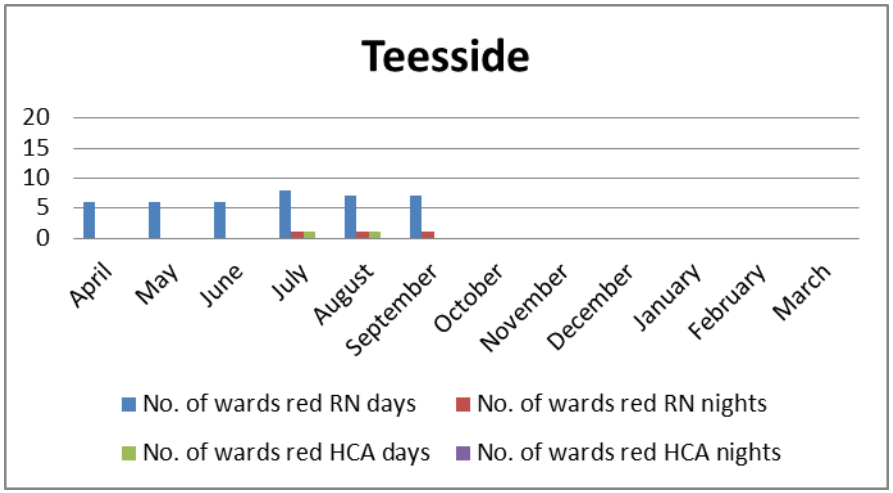
Month	Draft Submission							
	Day				Night			
	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month	Average Fill Rate - Registered Nurses / Midwives (%)	Trend on Prev Month	Average Fill Rate - Care Staff (%)	Trend on Prev Month
May-14	65.90		86.20		96.30		99.90	
Jun-14	94.15	↑	109.00	↑	100.80	↑	113.00	↑
Jul-14	90.75	↓	110.00	↑	99.68	↓	111.00	↓

Aug-14	85.75	↓	107.14	↓	99.60	↓	109.00	↓
Sep-14	92.99	↑	105.27	↓	99.67	↑	109.43	↑
Oct-14	92.63	↓	108.82	↑	99.09	↓	108.67	↓
Nov-14	91.84	↓	109.38	↑	99.41	↑	108.98	↑
Dec-14	90.79	↓	102.47	↓	98.22	↓	107.13	↓
Jan-15	92.54	↑	105.31	↑	98.91	↑	108.42	↑
Feb-15	92.65	↑	107.14	↑	102.52	↑	109.17	↑
Mar-15	91.99	↓	106.64	↓	100.62	↓	110.48	↑
Apr-15	93.12	↑	111.42	↑	101.19	↑	111.20	↑
May-15	93.00	↓	110.34	↓	102.27	↑	110.09	↓
Jun-15	93.12	↑	109.50	↓	100.62	↓	112.27	↑
Jul-15	90.80	↓	114.10	↑	99.40	↓	115.30	↑
Aug-15	87.90	↓	112.60	↓	98.10	↓	110.10	↓
Sep-15	90.3	↑	113.6	↑	98.20	↑	112.6	↑

Appendix 5







Appendix 6

Scored Fill Rate compared to Quality Indicators - SEPTEMBER					Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers	Total score	Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI	Level 4 Incidents	Level 3 (Severe Harm) Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total

Aysgarth	Teesside	LD	6	9	2253.19	674.01	30%									
Tunstall Ward	Durham & Darlington	AMH	20	10	2736.67	300	11%									
Westerdale South	Teesside	MHSOP	14	9	4462.9	3346.47	75%				1	1	6	0	8	8
Earlston House	Durham & Darlington	AMH	15	9	2645.31	317.65	12%									
Bankfields Court Unit 2	Teesside	LD	5	9	2239.68	449.28	20%						1	0	1	1
Holly Unit	Durham & Darlington	CAMHS	4	9	1460.13	79.51	5%									
Lincoln Ward	Teesside	AMH	20	8	3101.48	489.5	16%						2	0	2	2
Westerdale North	Teesside	MHSOP	18	11	2698.5	82.25	3%						1	0	1	1
Westwood Centre	North Yorkshire	CAMHS Tier 4	12	9	4894	1417.75	29%			1			66	5	129	134
Farnham Ward	Durham & Darlington	AMH	20	9	2772.66	82.66	3%				1					
Hamsterley Ward	Durham & Darlington	MHSOP	10	13	2538.6	255	10%						1	0	1	1
Mallard Ward	Forensics	FMH	16	13	3541.59	1051.75	30%									
Rowan Ward	North Yorkshire	MHSOP	12	10	3097.5	343.5	11%						5	0	5	5
Ceddesfeld Ward	Durham & Darlington	MHSOP	10	13	2655.5	243	9%					1				
Elm Ward	Durham & Darlington	AMH	20	9	3278.34	1188	36%						1	0	1	1
Stockdale Ward	Teesside	AMH	18	13	2823	732.5	26%					1	1	0	1	1
Northdale Centre	Forensics	FMH	6	11	4484.37	1286.99	29%						4	1	14	15
Bedale Ward	Teesside	AMH	10	13	3387.5	1313	39%						14	3	21	24
Bek, Ramsey, Talbot Wards	Durham & Darlington	LD	16	8	6260.67	853.73	14%						6	2	11	13
Brambling Ward	Forensics	FMH	13	13	2893.25	1431.25	49%			1			8	0	10	10
Bransdale Ward	Teesside	AMH	14	11	2558.33	897.58	35%				1		1	0	2	2
Lustrum Vale	Teesside	AMH	20	11	2486.5	478.5	19%						2	0	2	2
Bilsdale Ward	Teesside	AMH	14	12	2513	638	25%						1	0	1	1
Birch Ward	Durham & Darlington	AMH	15	9	3180.5	270.33	8%									
Cedar Ward (NY)	North Yorkshire	AMH	18	12	4104.92	605.75	15%			1		1	15	6	19	25
Eagle/Osprey	Forensics	FLD	10	9	3699.8	845.25	23%									

Maple Ward	Durham & Darlington	AMH	17	11	3222.56	1624.67	50%					1				
Picktree Ward.	Durham & Darlington	MHSOP	10	11	2663.16	1083.83	41%									
Primrose Lodge	Durham & Darlington	AMH	15	11	2510.99	132	5%									
Newberry Centre	North Yorkshire	CAMHS Tier 4	14	9	3099.58	557.6	18%					1	16	0	30	30
The Evergreen Centre	North Yorkshire	CAMHS Tier 4	12	11	3819.65	624.45	16%					2	35	4	66	70
Ward 14	North Yorkshire	MHSOP	9	13	2377.92	19.5	1%						4	0	6	6
Willow Ward	Durham & Darlington	AMH	15	13	3183.83	1044	33%					1	1	1	1	2
Baysdale	Teesside	CAMHS	6	8	2487.18	32.34	1%									
Langley Ward	Forensics	FLD	10	12	2391.09	349	15%									
Merlin	Forensics	FMH	10	10	4379.17	2690.75	61%					3	4	0	4	4
Oak Ward	Durham & Darlington	MHSOP	12	11	2159.51	103.68	5%									
Oakwood	Forensics	FLD	8	12	1942.75	206.75	11%									
Bankfields Court	Teesside	LD	12	12	8130.59	1112.03	14%									
Park House	Teesside	AMH	14	11	2382.7	383	16%					1				
Cedar Ward	Durham & Darlington	AMH	10	9	3868.26	1660.66	43%					1	2	1	3	4
Fulmar Ward.	Forensics	FMH	12	13	3001.55	956	32%						2	0	5	5
Jay Ward	Forensics	FMH	5	13	2940.55	841.25	29%						4	1	11	12
Kingfisher/Heron/Robin	Forensics	FLD	14	11	2957.05	283.84	10%									
Nightingale Ward	Forensics	FMH	16	12	2696.45	721.75	27%					1	1	0	2	2
Sandpiper Ward	Forensics	FMH	8	8	4455.12	1912	43%						26	7	74	81
Springwood Community Unit	North Yorkshire	MHSOP	14	13	3174.7	709.17	22%						4	0	4	4
Thistle Ward	Forensics	FLD	5	9	2598.57	359.42	14%						4	0	4	4
Ward 15 Friarage	North Yorkshire	AMH	14	13	2682.5	712.25	27%						2	0	3	3
Overdale Ward	Teesside	AMH	18	12	2752.5	714	26%					1				
Linnet Ward	Forensics	FMH	17	11	2835.75	803.65	28%					1	1	0	1	1
Swift Ward	Forensics	FMH	10	12	3086.8	767.25	25%					1	2	0	3	3

Ayckbourn Unit Esk Ward	North Yorkshire	AMH	13	10	2651.34	301.8	11%						7	1	9	10
Ayckbourn Unit Danby Ward	North Yorkshire	AMH	13	10	2487.48	664.34	27%									
Clover/Ivy	Forensics	FLD	12	10	4078.52	1072.09	26%					1	1	0	2	2
Kirkdale Ward	Forensics	FMH	16	13	3152.85	542	17%					2				
Roseberry Wards	Durham & Darlington	MHSOP	15	8	2695	156	6%					1				
Lark	Forensics	FMH	15	12	2785.37	640.75	23%									
Wingfield Ward	Teesside	MHSOP	9	12	2308	52.5	2%									
Kestrel/Kite	Forensics	FLD	16	9	3775.67	810	21%					6				
Abdale House	North Yorkshire	AMH	9	10	2372.68	46	2%									
Mandarin	Forensics	FMH	16	13	2787.75	350.75	13%					1	3	0	4	4
Rowan Lea	North Yorkshire	MHSOP	20	13	3704.83	147.01	4%						8	0	12	12
Newtondale Ward	Forensics	FMH	20	12	3572.68	522	15%					1				
Harrier/Hawk	Forensics	FLD	10	13	4072.76	668.5	16%	1				2	3	0	3	3

Item 8a

FOR GENERAL RELEASE

Board of Directors

Date of Meeting: **Tuesday 27th October 2015**

Title: **Update on implementation of Clinical Supervision**

Lead Director: **Elizabeth Moody, Director of Nursing**

Report for: **Discussion/Decision**

This report includes/supports the following areas:

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

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

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

Board of Directors

Date of Meeting: **Tuesday 27th October 2015**

Title: **Update on implementation of Clinical Supervision**

1. INTRODUCTION & PURPOSE

1.1 The purpose of this paper is to provide an update to the Clinical Management Supervision Protocol and proposed changes to the Supervision Policy.

2. BACKGROUND INFORMATION

2.1 The CQC paper, 'Supporting information and guidance: Supporting effective clinical supervision', (July 2013), states that: *"Clinical supervision should be valued within the context of the culture of the organisation, which is crucial in setting the tone, values and behaviours expected of individuals. A range of professional bodies provide guidance about what they consider to be an appropriate frequency and duration for different groups. Providers, registered managers and staff should refer to the appropriate professional body for advice on frequency".*

2.2 The Trust CPA Review made particular recommendation of direct relevance: *"Recommendation 22 - To ensure the systems and standards for training, supervision and case management of care co-ordinators and lead professionals includes values and principles of care co-ordination and compassionate care".*

2.3 Review and development of clinical supervision was a key recommendation of the Malcolm Rae Overview report (2013): *"We consider it would be beneficial to give greater attention to supervised practice, both individual and group supervision in providing support, encouragement and an opportunity for practitioners to ask questions, raise concerns and clarify their thinking"*

2.4 The requirement for clinical staff to receive supervision to monitor, facilitate and develop the quality of clinical casework practice is embedded in all professional regulatory codes and is accepted as desirable within the Trust. The existing Supervision Policy (CLIN/0035/v4 (1)) sets out a generic framework for all staff.

Within the generic policy, however, clinical supervision is set out as an additional process to managerial supervision, where *"The function is the quality and effectiveness of the clinical practice delivered by the clinician. The focus tends to be on educative and supportive functions and guided reflection on the employee's clinical work is the primary tool. The agenda is more the responsibility of the supervisee, though the supervisor may set a framework to work within and bring items to consider e.g. case review as a regular item"*

2.5 Lack of/limited or poor quality clinical supervision is regularly implicated in serious untoward incident reviews; internal work including clinical audits confirms that supervision is inconsistently applied and quality is neither monitored nor assured. The current policy is not being applied consistently and potentially the resource implications of the current policy framework are not deliverable within the current organisational structures.

3. KEY ISSUES:

3.1 It appears from review that the intention of the current Trust policy (2012) to ensure all employees have managerial supervision and then in addition have clinical supervision, delivered by a clinical expert of their choice, is not being consistently achieved.

There is also evidence from audit, incident and complaint review that ensuring clinical staff are delivering effective and best practice compliant casework is not always a core element of the line management function, particularly where the practitioner may have a separate clinical supervisor and the tri-partite review, outlined in the policy, is not occurring.

York and Selby services will need to be included in all future development and discussions

3.2 The Trust policy position has been amended to reflect that:

a) all employees will receive a minimum of four hours managerial supervision from their line manager in each financial year, in addition to their developmental review (appraisal) meeting which would take place once per year.

b) all employees delivering clinical practice will receive a minimum of 12 hours per year of clinical management supervision where their line manager is a practising clinician. The purpose and focus of this supervision would integrate the current managerial and clinical functions.

c) employees delivering clinical practice where their line manager is not a practising clinician will receive a minimum of four hours managerial supervision a year from their line manager (in addition to their developmental review meeting which would take place once per year) plus a minimum of 8 hours per year of clinical management supervision from a senior clinician approved, by their line manager. The clinical management supervision would integrate the current managerial and clinical functions as in the protocol.

d) registered nursing staff, delivering direct clinical practice, where their line manager is not a practising clinical nurse will ensure their clinical management supervision is delivered by the senior nurse who will complete their revalidation approval/sign off.

e) There are other supervision requirements e.g. safeguarding supervision or professional or training or group supervision that would be negotiated separately

dependent upon the clinical context, specific role, profession or casework of a clinical practitioner.

f) A separate protocol which sets out the requirements for clinical management supervision is added to the policy with minimum competencies for supervisors and standard recording requirements.

3.3 A Trustwide implementation plan to include the final policy amendments, the development of standard documents, baseline scoping of clinical supervisory capacity requirements, baseline supervisor competency assessment, top up training for supervisors, briefing and spot audit will be progressed through 2016/17. .This programme will be led by the Heads of Nursing in each locality.

3.4 At the EMT on 15th June 2015 it was agreed that there was a need to standardise clinical supervision arrangements across the Trust. Time allocation has been re-worded to state hours rather than sessions.

4. IMPLICATIONS / RISKS:

4.1 **Quality:** Research has demonstrated that good quality supervision can enhance the quality of clinical care delivery and an absence of regular supervision leads to missed opportunities for care improvement, learning lessons and challenging of inappropriate behaviours and standards. Implementing a consistent and standard approach to clinical supervision and ensuring it is being delivered across the clinical workforce will positively impact upon quality standards.

4.2 **Financial:** There are no direct financial implications at this stage however the current inconsistent delivery of clinical supervision may be related to a capacity or resource issue. The initial capacity scoping will identify what is required to successfully implement a Trust wide standard approach. There may also be additional financial requirements to resource training delivery.

4.3 **Legal and Constitutional:** The CQC statements in 2013 identify the regulatory risks of inability to demonstrate a cohesive clinical supervision framework in place across the registered services. The professional regulatory bodies vary in the requirements for supervision.

4.4 **Equality and Diversity:** Any implementation would have demonstrated equal access across geographical and professional groups, with ability to respond to individual learning requirements.

4.5 **Other Risks:** Poor quality supervision, inconsistently delivered by incompetent supervisors/managers can have a detrimental impact on clinical care by undermining confidence and not challenging capability or attitudinal issues. Staff who have experienced poor quality supervision will be reluctant to engage in the process and this risks the consistent application of a cohesive supervisory framework. The implementation plan and standards will need to work to mitigate this.

5. CONCLUSIONS

5.1 Changes have been agreed to introduce clinical management supervision to integrate the current line management supervision with clinical supervision to achieve consistent standards, both in the model and the competencies of the supervisor.

5.2 The Deputy Director of Nursing, supported by the Head of Professional Nursing and Education will co-ordinate the Trust wide approach to the implementation plan.

5.3 The Heads of Nursing will support and progress the implementation plan. Following the ratification of revalidation at the NMC Council (8.10.15), further development of the clinical supervision documentation is required in order to embed the two processes together.

5.4 The reflective element requirement of revalidation around practice feedback and subsequent development supports the clinical supervision process. Furthermore the new NMC Code of Conduct 2015 states that nurses must act on any feedback received to improve practice.

6. RECOMMENDATIONS

6.1 The Board of Directors are asked to consider the update and support the ongoing work with regard to the Policy and Implementation plan.

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Elizabeth Moody
Director of Nursing and Governance

IMPLEMENTATION PLAN FOR CLINICAL MANAGEMENT SUPERVISION PROTOCOL

PLAN LOCATION/TEAM: Trustwide PLAN DEVELOPED BY: Elizabeth Moody DATE PLAN AGREED: To agree at EMT Dec 15

NO.	RECOMMENDATION/FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
1	"We consider it would be beneficial to give greater attention to supervised practice, both individual and group supervision in providing support, encouragement and an opportunity for practitioners to ask questions, raise concerns and clarify their thinking" *Rae review*	To have updated the Trust Supervision Policy to reflect the recommendations from the Rae review and the lessons identified from SUI reviews	To finalise the amendments to the Trust Supervision Policy.	Director of N&G	September 30th 2015	New policy with CSM protocol	
2	Implementation of separate clinical supervision in addition to managerial supervision is inconsistent and quality varies across Trust	To have robust framework in place for delivery of clinical supervision with clear standards of practice	To amend the Trust Supervision Policy and add the Clinical Management Supervision (CSM) Protocol	Director of N&G	September 30th 2015	New policy with CSM protocol	
3	Implementation of separate clinical supervision in addition to managerial supervision is inconsistent and quality varies across Trust	To have a locality implementation plan in place	To develop a locality implementation plan to take into account resources required to comply with the CSM protocol and Supervision Policy requirements	Heads of Nursing	January 2016	Locality implementation plans	**Heads of Nursing not in post**

	Key elements of clinical practice not being addressed in supervision	Core requirements of clinical practice to ensure compliance with best practice and regulatory requirements included in supervision	To draft a standard agenda document for CSM sessions that is mandated	Director of N&G	September 30th 2015	Standard Agenda doc.	
5	Inability of clinical teams to produce consistent evidence of supervision implementation and content	Clear audit trail to produce evidence of CSM implementation	To draft a standard recording sheet for CSM sessions	Director of N&G	September 30th 2015	Standard recording sheet	
6	Variance in quality, engagement and benefits from clinical supervision	Clear expectations set for all staff delivering clinical practice - regarding CSM and the standards of supervisory practice and process	6.1To draft a briefing sheet and guidance notes for supervisees for CSM	Director of N&G	September 30th 2015	Briefing sheet	
			6.2 To draft a briefing sheet and guidance notes for managers and supervisors for CSM	Director of N&G	September 30th 2015	Briefing sheet	
7	Variance in the skills and capabilities of staff delivering supervision	Clear standards of supervisory practice set out for those delivering supervision	To design a competency framework and assessment for managers and supervisors	Director of HR/OD	December 2015	Competency framework	
		Competent supervisory practice delivered across the Trust	To design a training curriculum for managers and supervisors	Director of HR/OD	December 2015	Training curriculum document	

8	Variance in quality, engagement and benefits from clinical supervision	Competent supervisory practice delivered across the Trust	9.1 To complete the competency assessment for manager-supervisors and professional supervisors	Director of Ops	November 30th 2015	Competency reports	**Meeting to discuss competency Framework and training 15.10.15**
			9.2 To deliver the top up training programme for manager-supervisors and professional supervisors	TBA	March 31st 2016	Training programme and attendance	
			9.3 To deliver staff briefings to all staff re their role as supervisee.	TBA	March 31st 2016	Attendance report	
9	Lack of compliance with current Trust Supervision policy	All staff aware of the requirements of the Trust Supervision policy	10.1 To agree launch programme for amended Supervision Policy and CSM protocol	Director of N&G	April 2016	Programme	
			10.2 To deliver the launch programme for CSM protocol	Director of N&G	April 2016	Programme	
		Assurance information available about compliance with policy and protocol	10.3 To design the spot audit monitoring programme	Director of N&G	In progress	Attendance report	
			10.4 To deliver the spot audit monitoring programme for Year 1.	Director of Ops	March 31st 2017	Assurance report	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

FOR GENERAL RELEASE

ITEM 8b

TRUST BOARD MEETING

Date of Meeting: **Tuesday 27th October 2015**

Title: **Progress report on the Trust Clinical Risk and Harm Minimisation Project**

Lead Director: **Elizabeth Moody, Director of Nursing and Governance**

Report for: **Discussion**

This report includes/supports the following areas:

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

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

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

TRUST BOARD MEETING

Date of Meeting: **Tuesday 27th October 2015**

Title: **Progress report on the Trust Clinical Risk and Harm Minimisation Project**

1. INTRODUCTION & PURPOSE

1.1 The purpose of this paper is to provide an update to Trust Board about the Progress made to date on the Clinical Risk and Harm Minimisation Project:

- The PM1 form was approved by EMT on 18th August 2015
- The PM3 is due to EMT November 2015

2. BACKGROUND INFORMATION

2.1 The current Trust Clinical Risk Assessment and Management (CRAM) Policy does not reflect the principles within the Trust Recovery Strategy which was endorsed by the Trust in 2013. The project will support the fourth outcome of the ten year strategy, which is to transform current approaches to risk through embedding recovery principles into training, updating current policies and frameworks, and implementing processes for teams to assess risk.

2.2 This is consistent with the "Rae Review" (the independent review into the circumstances of the four deaths of service users during February 2013). Its recommendations included replacing CRAM and phasing out FACE as a default risk assessment tool, and developing a new over-arching framework including the delivery of appropriate training.

2.3 Staff training in clinical risk assessment tools was originally delivered with the CPA and Paris training with the original roll-out of Paris. Currently CRAM training is mandatory and mainly delivered by e-learning. There is little evidence that training is linked to desired outcomes in supporting staff in assessing risks, developing risk management plans with patients/carers and accurate recording on Paris.

2.4 Overly defensive approaches to clinical risk lead to negative outcomes for both patients and the Trust. The Trust Board supports the principles of positive risk management, as outlined in its approach to the management of patients diagnosed with borderline personality disorder. This needs to be embedded into both policy and practice (culture).

2.5 Currently there are multiple work streams within the Trust aimed at improving clinical risk assessment e.g. CPA, Model Lines, Force Reduction, Recovery and Suicide Risk Mitigation. In addition the clinical specialities have been piloting new approaches to risk management, such as narrative formulations. This project will align the risk and harm minimisation aspects of the other projects in line with recovery principles.

3. KEY ISSUES:

3.1 The aims of the project is to:

- Develop and disseminate a new policy for harm minimisation which reflects a Recovery Culture, including how in-patient engagement and observation is practiced. This will replace the current CRAM policy.

- Develop training around harm minimisation practice across the Trust, including that identified within the suicide risk mitigation project.

- Develop an overall framework for supervision in harm minimisation which reflects the planned redesign of supervision policy and practice.

- Develop a Trust Strategy on Harm Minimisation, and explore making this a regional strategy.

- York and Selby services are to be included in the project and contact has been made to gather information regarding current practice.

3.2 An expert by experience has been identified and will be attending the next steering group meeting. An update on the project has been delivered to both of the Trust Leadership & Network group meetings in October and one is planned for York and Selby in November. Group work at these events relating to training options will be used to inform the PM3 options paper.

3.3 Harm minimisation will be embedded within the Recovery Project Stage 2 Business Plan which will allow for continued alignment

3.4 The Harm Minimisation Project Lead has commenced Sign Up to Safety Roadshows with the Force Reduction Project Manager to inform staff across the Trust about the Harm Minimisation, Force Reduction and Learning Lessons Projects. The Project Lead will also be attending QuAGs, SDGs and LMGBs across the Trust to inform them of the Sign up to Safety campaign October to January. A Harm Minimisation Project page has been set up on InTouch

3.5 The Project will consider how to embed Harm Minimisation training into any relevant training that is already available or is currently being developed across the Trust to ensure consistency of language and approach.

4. IMPLICATIONS / RISKS:

4.1 **Quality:** The development of the proposed framework will improve the quality of clinical risk assessment and management, supporting the Recovery Strategy, effective Care Co-ordination and Harm Minimisation. High level co-ordination of the interdependencies of related projects with one clear organisational focus will reduce organisational risk, reduce waste and produce a more coherent direction and reduce duplication. The proposals will support the current Quality Strategy.

4.2 **Financial:** There may be direct and/or indirect financial implications in regard to training in formulation and narrative based risk assessment approaches and clinical supervision. However co-ordination of projects will reduce duplication and waste.

4.3 **Legal and Constitutional:** Effective person centred care is a requirement as a fundamental standard under the Health and Social Care Act (2014) and ensuring safe care is a requirement of the new CQC regulations. Reducing use

of restrictive practice and blanket restrictions will be enabled by this framework which are key requirements to ensure regulatory compliance.

4.4 **Equality and Diversity:** Implementing a more person centred, recovery focussed framework will ensure equality of approach.

4.5 **Other Risks**: Implementing a narrative and formulation based risk assessment requires a range of skills and competencies that evidence suggests are not currently in place across the clinical workforce. There will be risks that those competencies may be able to be developed.

5. CONCLUSIONS

5.1 If successful this project will aim to deliver the following benefits:

- A measured increase in personal risk and safety plans that demonstrate clear formulation of risk and show direct correlation to the care and/or intervention plan.
- A measured increase in the number of personal risk and safety plans that demonstrate co-production with service users, their families and/or carers.
- A competency framework for staff engaged in direct clinical practice in relation to effective harm minimisation and risk management, using competency assessment methods.
- A measured reduction in the occurrence of inadequate risk management practice as a root or contributory finding in the review of serious incidents from baseline.
- Development of an agreed set of practice standards for the initiation, maintenance and termination of engagement and observation procedures based on the principles of harm minimisation intervention.

6. RECOMMENDATIONS

6.1 Trust Board are asked to consider the update and support the on-going development of the project.

Elizabeth Moody
Director of Nursing and Governance

GENERAL RELEASE

ITEM 9

BOARD OF DIRECTORS

Date of Meeting: **Tuesday 27 October 2015**

Title: **Out of Locality Admissions Action Plan**

Lead Director: **Brent Kilmurray, Chief Operating Officer**

Report for: **Decision/ Information**

This report includes/supports the following areas:

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

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

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

BOARD OF DIRECTORS

Date of Meeting: **Tuesday 27 October 2015**

Title: **Out of Locality Admissions Action Plan**

1. INTRODUCTION & PURPOSE

1.1 To provide a progress update report on the Out of Locality Action Plan.

2. BACKGROUND INFORMATION

2.1 The original report submitted to the Board of Directors in June 2014 outlined the key matters relating to Out of Locality admissions to acute inpatient beds:

- June 2014 revealed almost a quarter (24.7%) of admissions over the previous 12 month period were outside of a patient's own locality.
- The highest level of out of locality admissions are recorded as 30.1% during April 2014
- Variations in admissions and readmission rates across the specialty.

2.2 Whilst improvements had been made with locality level actions, such impact(s) had not been sustained.

2.3 The Board agreed the implementation of a Trustwide Action Plan which included actions relating to admission and readmission rates across the Adult Specialty.

2.4 The action plan intended to address the evident variation in occupied bed days, the impact of home treatments provided by community mental health services and their efficacy.

3. KEY ISSUES:

3.1 The percentage of Out of Locality admissions continued to fall in June 2015 (14.24%) and July 2015 (13.21%), though rose again in August 2015 to 17.5%. This has been followed by a significant reduction to 5.1% in September. Changes to admissions to wards post the closure of Bootham Park may have an impact on the clarity of reporting in the future.

3.2 Crisis Team training with representatives from all teams took place in September. This training is currently undergoing evaluation which will be shared with the Crisis Teams leadership network to support the development of a roll out plan. The Network will also support related work to ensure the training meets the need of the teams and improvements can be sustained. The evaluation is being undertaken within the Trust supported by input from OD staff. The Trust is working with NTW although this has been on hold due to sickness at NTW.

3.3 All other actions have been previously completed.

4. IMPLICATIONS / RISKS:

4.1 **Quality:**
Out of Locality admissions are a key concern regarding the quality of services, inclusive of customer satisfaction. This Action Plan sought to reduce the numbers of patients being admitted out of locality and the subsequent pressure on inpatient beds.

4.2 **Financial:**
There is a financial implication arising from the delivery of training detailed within the action plan update.

4.3 **Legal and Constitutional:**
None.

4.4 **Equality and Diversity:**
None.

4.5 **Other Risks:**
None.

5 CONCLUSIONS:

The attached action plan has been updated to reflect the progress that has been made against the recommendations set out to improve the quality of care provided within a service user's own locality. Since the last report the Crisis Team Home Treatment training has been completed. Therefore, there are now no outstanding actions within the plan.

6 RECOMMENDATIONS:

The Board is asked to support the closing of this plan.

Brent Kilmurray
Chief Operating Officer

Background Papers:

The most recent Data Tables have been included.

OOL Appendices - August 15.pdf

OOL Appendices - Sept 15.pdf

STANDARD ACTION PLAN

Out of Locality Admissions Action Plan **PLAN DEVELOPED BY: Mr B Kilmurray** **DATE PLAN AGREED: June 2015**

NO.	RECOMMENDATION /FINDING	INTENDED OUTCOME /RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
1	Crisis Team staff undertake less home treatment than might be expected. There is an opportunity to ensure that all staff have the appropriate level of skill	Staff are skilled in the delivery of a range of home treatments	Appoint an Expert Practitioner to deliver training	COO	September 2014	Expert Practitioner appointed	Secondee in post for completion of work set out as agreed. The secondment has been extended to end of January 2016
			Expert Practitioner to develop training material and roll out a programme of training to all CRT staff	Expert Practitioner	September 2015	Training material developed Training delivered	Secondee has developed training materials; training programme and aide memoires based upon the

NO.	RECOMMENDATION /FINDING	INTENDED OUTCOME /RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
							priorities reflected by both national guidelines (HTAS) and the crisis team staff members. Initial training was completed with representatives from all Crisis teams. This training is subject to evaluation and roll out of training will be guided by feedback from attendees and managers. A crisis teams leadership network has commenced to take forward

NO.	RECOMMENDATION /FINDING	INTENDED OUTCOME /RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
							this evaluation and related work.
2	Clinicians are not sufficiently recovery focussed and are at times risk averse.	Service users have co-produced, high quality care plans that seek to maintain treatment in the community rather than admission to hospital.	Review of Clinical Risk Assessment and Management Policy framework	Ahmad Khouja	September 2014	Revised policy framework agreed	Framework review complete.
			Risk documentation is reviewed and replaced with more effective shortened approaches	CPA Project Manager	September 2014	New shortened documentation available	Risk documentation reviewed and a shortened assessment document has been developed.
			A new bespoke local induction programme for new Crisis Team staff to be created and implemented	Expert Practitioner	April 2015	Induction material available and managers briefed on requirements	The induction programme has been developed in module format so as to be part of ongoing training and is

NO.	RECOMMENDATION /FINDING	INTENDED OUTCOME /RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
							linked with training materials/ programme above
3	CRTs are used as a fast track access service by referrers	Access Teams offer urgent appointments within 72 hours	Create slots for urgent referrals in Access Services and CMHT	Locality Managers	October 2014	Appointment schedules have slots for urgent appointments	**Complete**
4	Clinical management plans are not always followed outside of normal working hours Services are working with an incorrect or interpreted view of procedures, criteria and processes between teams and across services	Good quality crisis and contingency plans are available to all service users	Establish standard work on crisis planning through a Kaizen event Establish a standard approach to the format and recording of crisis plans		January 2015 January 2015	Standard work is available and cascaded to teams Processes are documented and there is a good level of knowledge of the service	**Complete Crisis Planning (Affective and Psychosis Model lines) Written within the standard processes.** **Place of storage agreed** **Exemplar tool adopted**

NO.	RECOMMENDATION /FINDING	INTENDED OUTCOME /RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
	Patient focussed approach such as PIPA.	Teams have a clearer view of workload.	Review visual control in the CRTs and improve on the best practice for tracking referrals, workload management, stop the line and daily communication		January 2015	Standardised visual control is established in each CRT	Review of VCB across all teams completed. Kaizen event complete
5	There is variation in the performance of CMHT in keeping people well and out of hospital and from preventing readmissions	Variation between the best and worst performing teams is reduced	Work with the Directorate leadership team to develop bespoke development plans for the five teams with the highest levels of admission and readmissions. Analysis will also consider	COO	August 2014	Action plans are produced and signed off by Locality Contract and Performance meetings and reported to Performance Improvement Group	**Complete**

NO.	RECOMMENDATION /FINDING	INTENDED OUTCOME /RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
			whether deficits with discharge planning play any role.				
6	Richmondshire has a high admission rate	There will be a better understanding of why more patients are admitted from Richmondshire, which may indicate measures that can be taken to reduce admissions	The last 40 patients admitted from Richmondshire will be subject to a case note review to understand why they were admitted A report will be produced with recommendation on the main themes and actions for the relevant teams	Locality Manager and Clinical Director	September 2014	Paper will be produced with analysis and findings of case note review	**Complete – however was not complete on time. Review was complete March 2015** **Complete. Programme of work now developed and underway. Report will be presented to AMH NY QUAG in June 2015**
7	Not sufficient use is made of	Gain a better	Generate a	Locality	September	A list of	**Complete**

NO.	RECOMMENDATION /FINDING	INTENDED OUTCOME /RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
	other services. Teams could provide better sign posting to other, perhaps more appropriate, sources of support from third sector organisations.	understanding of the provision available locally.	guide for staff setting out the key services	Managers	2014	services available will be published in each locality	

Item 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: Tuesday 27th October 2015

Title: Trust's response to the consultation on the Deprivation of Liberty Safeguards being undertaken by the Law Commission

Lead Director: Elizabeth Moody, Director of Nursing and Governance

Report for: Decision

This report includes/supports the following areas:

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

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

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

BOARD OF DIRECTORS

Date of Meeting: **Tuesday 27th October 2015**

Title: **Trust's response to the consultation on the Deprivation of Liberty Safeguards being undertaken by the Law Commission**

1. INTRODUCTION & PURPOSE

1.1 The purpose of this report is to briefly apprise the Board of the proposals of the Law Commission in relation to the Deprivation of Liberty Safeguards (DoLS) consultation.

1.2 To seek the approval of the Board in relation to the contents of the Trusts response to the consultation prior to submission to the Law Commission no later than 2nd November 2015.

2. BACKGROUND INFORMATION

2.1 The DoLS have been subject to considerable criticism ever since their introduction. In March 2014 two events inflicted significant damage. First, the House of Lords post-legislative scrutiny committee on the Mental Capacity Act (the "House of Lords committee") published a report which, amongst other matters, concluded that the DoLS were not "fit for purpose" and proposed their replacement. A few days later, a Supreme Court judgment (*Cheshire West*) widened the definition of deprivation of liberty to a considerable extent. The practical implications have been significant for the public image of the DoLS, and the regime has struggled to cope with the increased number of cases.

2.2 The Law Commission project originated from a proposal from Mind for a review of the relationship between the DoLS and the Mental Health Act 1983. In light of the House of Lords committee's report and the *Cheshire West* decision, the Government originally asked the Law Commission to undertake a limited review of deprivations of liberty in supported living arrangements and other community settings, and to consider the learning that could be applied to the DoLS. Following subsequent engagement and discussion with stakeholders, Ministers agreed that it would be more appropriate for the Law Commission to consider the legislation underpinning DoLS in its entirety, in addition to its work on community settings (including supported living).

2.3 The Trust has drafted a response addressing a number of the most relevant key proposals which was circulated to all medical clinical leaders for comments.

3. KEY ISSUES:

3.1 The Law Commission document – Mental Capacity and Deprivation of Liberty, A Consultation Paper – is a 230 page document broadly setting out the proposals to revise the DoLS legislation and includes a number of other key proposals to support

the changes. The document does not go into significant detail around how the proposals will work in practice and at consultation events, the Law Commission have pointed out that the detail will be required in the drafting of the legislation itself if the proposals are to be taken forward. This has made commenting on the proposals, other than in broad terms, quite difficult.

3.2 A chart at appendix 1 sets out the key provisions of the 'Protective Care' scheme. The Law Commission proposals are much wider than merely authorising deprivations of liberty and extend to the provision of safeguards for anyone entering an acute hospital, care home, supported living or shared lives accommodation setting where they lack the capacity to consent to those arrangements, whether there is a deprivation of liberty or not. It also extends to deprivations of liberty in domestic settings.

3.3 The Law Commission have also made it clear in their proposals that entering hospital for the primary purpose of treatment for mental disorder in the absence of a capacitated consent should sit outside of the Mental Capacity Act and the new scheme and should be safeguarded through use of the Mental Health Act. They propose an amendment to the MHA to allow for the admission of incapacitated compliant patients under that Act.

3.4 The proposed safeguards include, as a minimum, access to advocacy or an 'appropriate person', that all people subject to 'protective care' in whatever form will have the involvement and oversight of an Approved Mental Capacity Professional (AMCP) and then includes a relevant person's representative, access to a First Tier Tribunal and in some instances access to the Court of Protection.

3.5 The proposals place significant responsibility on Local Authorities to oversee all of the processes associated with the new scheme and the Law Commission envisages the introduction of a new professional – the Approved Mental Capacity Professional - who has significant autonomy and decision-making responsibility, including with regard to authorising a deprivation of liberty.

3.6 The document also makes proposals with regard to a number of other related issues including supported decision making and best interests, advance decision making, regulation and monitoring, 16 and 17 year olds, criminal offences (should unlawful deprivation of liberty become a criminal offence), Coroners responsibilities and paying for care and treatment whilst subject to a deprivation of liberty.

3.7 The timescales for any changes to DoLS legislation as a result of this consultation, if any changes are made, are likely to be quite lengthy. The Law Commission aim to publish recommendations in 2016. However, if the consultation responses lead to significant change there may be another period of consultation. The recommendations will then be presented to Government and Parliament where a decision will be made whether to change the law. The legislation will then require drafting, the production of Green and White papers and development of a Bill until it is eventually enacted. The estimated timescale is 2020 at the earliest.

4. IMPLICATIONS / RISKS:

4.1 **Quality:** A significant number of the proposals at the 'supportive care' and non-dol 'restrictive care and treatment' end seek to place a further legislative framework around existing requirements under other legislation such as the Care Act. This, in theory, should help to improve compliance with the requirements of the Care Act, Continuing Healthcare, and other statutory assessment and treatment requirements which would potentially drive up quality.

4.2 **Financial:** The potential financial implications of the proposals are significant as are the workforce implications. The introduction of the AMCP role which carries not only authorisation powers but also an overseeing requirement in terms of monitoring the people subject to the 'protective care' scheme is vast and whilst the proposals envisage the AMCP replacing the Best Interests Assessor (BIA) under DoLS, the vast majority of BIAs carry out this role as an add on to their job which is becoming more and more difficult to fulfil resulting in lots of 'outsourced' assessments. The financial cost of the increased advocacy and the introduction of access to the First Tier Tribunal will also impact massively, a cost which the Law Commission feel may be offset by reducing the need to access to the Court of Protection as frequently, but which most Local Authority Senior Managers do not feel will be the case. The proposed scheme widens out dramatically the number of people who will be subject to it by removing the focus from Article 5 and the deprivation of liberty issues, to a greater focus on Article 8 rights in terms of respect for a private and family life.

5. CONCLUSIONS

5.1 It is clear that the current DoLS legislation is not fit for purpose and this has been illuminated by the Cheshire West judgment. The law Commission proposals are the first steps in changing that legislation, however they go a lot further than just amending the legislation in terms of authorising deprivations of liberty and attempt to changes the focus from Article 5 alone to include much greater consideration of Article 8 rights. It seems to be this broadening which is causing a level of consternation amongst professionals and whilst it is aspirational and would provide for significant safeguards for the most vulnerable in society, the resource implications are potentially insurmountable, particularly in the current financial climate.

6. RECOMMENDATIONS

6.1 The Board are asked to consider the content of the Trust Response document and approve it for submission to the Law Commission on November 2nd 2015.

Mel Wilkinson
Head of Mental Health Legislation

Background Papers:
Appendix 1 – Proposal flow chart
Appendix 2 – Trust Response

APPENDIX 1

PROTECTIVE CARE SCHEME
Overarching scheme. Available to people in hospital (acute), care homes, shared lives, supported living (as defined by Care Act 2105) and domestic accommodation

SUPPORTIVE CARE
Applies to people who lack capacity to consent to their accommodation and are living in care homes, supported living and shared lives accommodation (not hospitals) and provides a set of safeguards, provisionally called "supportive care".

RESTRICTIVE CARE AND TREATMENT
Applies to people who lack capacity to consent to their care and treatment (receiving restrictive care and treatment) which may or may not amount to a deprivation of liberty, and are living in care homes, supported living and shared lives accommodation (not hospitals) and to people living in domestic settings where it amounts to a dol

HOSPITAL SCHEME (ACUTE) (to also cover palliative care in some circumstances)
To authorise deprivations of liberty in NHS, independent and private hospitals where care and treatment is being provided for physical disorders, and in hospices where:

- the hospital/hospice patient lacks capacity to consent to the proposed care or treatment as a result of an impairment of, or a disturbance in the functioning of, the mind or brain; and
- there is a real risk that at some time within the next 28 days the patient will require care or treatment in his or her best interests that amounts to a deprivation of liberty; or
- the patient requires care or treatment in their best interests that amounts to a deprivation of liberty; and
- deprivation of liberty is the most proportionate response to the likelihood of the person suffering harm, and the likely seriousness of that harm.

SEPARATE FROM THE PROTECTIVE CARE SCHEME

MENTAL HEALTH SCHEME
The Mental Capacity Act (and our new scheme) **could not** be used to authorise the hospital admission of incapacitated people who require treatment for mental disorder. The Mental Health Act should be amended to establish a formal process for the admission of people who lack capacity and who are not objecting to their care and treatment. The safeguards provided would include an independent advocate, a requirement for a second medical opinion for certain treatments and rights to appeal to the mental health tribunal.

Appendix 2

Law Commission
Mental Capacity and Deprivation of Liberty
A Consultation Paper

RESPONSE TO PROVISIONAL PROPOSALS AND QUESTIONS

Please see the response of our organisation below. The Trust is a very large specialist mental health and learning disability provider organisation and the response reflects contrasting views expressed in relation to the consultation proposals and questions.

CHAPTER 2: ANALYSIS OF THE DEPRIVATION OF LIBERTY SAFEGUARDS

Provisional proposal 2-1: the Deprivation of Liberty Safeguards should be replaced by a new system called "protective care".

The trusts response fully supports the proposal to establish a new system of "protective care" replacing the present Deprivation of Liberty Safeguards arrangement.
From the proposals it appears that the 'Protective Care System' is a whole system approach looking at the care and treatment of anybody who lacks capacity to consent to the care and treatment proposed or provided in various settings and the 'Restrictive Care and Treatment' element of Protective Care is the replacement for DoLS within care homes, ISL and shared lives settings. There is then a separate scheme – the 'Hospital Scheme' – to authorise deprivations of liberty in hospital (acute rather than mental health and LD) to replace DoLS and then another provision – an amended MHA – to provide authority within mental health and LD hospital settings where the MCA under these proposals cannot be used to authorise a deprivation of liberty even in a compliant, non capacited person.

In that sense 'Protective Care' is replacing the DoLS, and that change in name is welcome, but also doing other things and a concern would be that those subject to the 'old DoLS' in care homes, ISL and shared lives settings would now be subject to 'Restrictive Care and Treatment ' which still sounds a little uncomfortable. A suggestion could be that 'Supportive Care' remains and those requiring more 'restrictive/intrusive care' could be referred to as requiring 'Enhanced Care'?

Provisional proposal 2-2: the introduction of protective care should be accompanied by a code of practice, and the UK and Welsh Government should also review the existing *Mental Capacity Act Code of Practice*.
Fully agree that the DoLS Code of Practice should be replaced by a Protective Care CoP and MCA CoP reviewed.

CHAPTER 3: PRINCIPLES OF PROTECTIVE CARE

Question 3-1: have we identified the correct principles to underpin protective care, namely that the scheme should deliver improved outcomes, and be based in the Mental Capacity Act, non-elaborate, compliant with the European Convention on Human Rights, supportive of the UN Disability Convention, and tailored according to setting?
Agree that the principles are correct, particularly with regard to being tailored according to setting. In relation to the 'non-elaborate' principle whilst this is a good principle it is difficult at this point to ensure that it will be adhered to until there are a more defined processes set

out, at the moment the processes look straightforward but the devil will inevitably be in the detail of the drafting of the legislation.

CHAPTER 4: THE SCOPE OF THE NEW SCHEME

Provisional proposal 4-1: the scope of protective care should include hospital, care home, supported living, shared lives and domestic accommodation.
Fully agree.
Attendance at Day Centres should be excluded for the reasons previously given i.e. that the protective care arrangements would cover the individual because of their living circumstances not the fact that they are attending a Day Centre.

Question 4-2: is the definition of supported living provided under the Care Act 2015 appropriate for our scheme?
The Care Act definition does provide a relatively clear distinction in terms of separation between ISL and somebody's own home – a domestic setting - which may or may not have been adapted but with carers attending (or even 'living in') which may give rise to imputibility to the state but is still 'their home'.

CHAPTER 6: SUPPORTIVE CARE

Provisional proposal 6-1: supportive care should apply where a person is living in care home, supported living or shared lives accommodation, or if a move into such accommodation is being considered.
Agree. Using Supportive Care in domestic settings would be overly intrusive and inappropriate. The only potential issue arising from that is that it could easily cross over into Restrictive Care or a potential deprivation of liberty without the preventative measures that Protective Care should provide.

Provisional proposal 6-2: supportive care should cover people who may lack capacity as a result of an impairment of, or a disturbance in the functioning of, the mind or brain, in relation to the question whether or not they should be accommodated in particular care home, supported living or shared lives accommodation for the purpose of being given particular care or treatment.
*Agree. There is no relevance to the definition of mental disorder for Supportive Care. The relevance of the presence of MD for DoLS purposes is to remain Article 5 compliant in terms of the presence of unsoundness of **mind**. As Supportive Care does not authorise a deprivation of liberty it is not a necessary element and lack of capacity is sufficient, the same test as currently used within the DoLS assessment process.*

Provisional proposal 6-3: a local authority should be required to undertake or arrange an assessment, or ensure that an appropriate assessment has taken place, where it appears that a person may be eligible for supportive care in care home, supported living or shared lives accommodation.
Agree. However, it must be clear in legislation who is accountable for identifying potential eligibility and notifying the LA when eligibility is triggered.

In order to prevent bureaucracy and additional assessments it is rightly envisaged that the LA will not usually undertake their own assessment but will rely on the assessments already required. What if, as is already the case quite often currently, the assessment of capacity is

of poor quality? Would the expectation be that it is at that point that the LA undertakes their own assessment?

Provisional proposal 6-4: the local authority must ensure that the assessor has the skills, knowledge and competence to carry out the assessment and is appropriately trained. The assessor must consult a person with expertise in relation to the condition or circumstances of the individual, where the assessor considers that the needs of the individual require them to do so.
Placing responsibility on the LA to ensure that the assessor has 'the skills, knowledge and competence to carry out the assessment and is appropriately trained' might prove difficult, particularly when the assessor may be from a completely different organisation and background. Who by, or how, will the required skills, knowledge, competence and level of training be determined?

Provisional proposal 6-5: local authorities should be required to keep under review the health and care arrangements for any person who falls within supportive care. This would include ensuring that a care plan and proper capacity assessments have been undertaken.
Agree. The proposals around Supportive Care appear to be trying to ensure that the systems and processes already in place which, for any number of reasons, may not be implemented as fully and as robustly as they could be are given an additional layer of oversight specifically in terms of those people who lack the necessary capacity to agree to the arrangements made for them.

It would seem pointless to introduce a scheme such as Supportive Care to provide safeguards in relation to the arrangements made for care for those who lack capacity and then to not oversee it in some way.

The trust supports this proposal but only if it is sufficiently resourced and there is an indication as to what is an appropriate frequency of review.

Provisional proposal 6-6: local authorities should be required to ensure that assessments and care plans record, where appropriate, what options have been considered and the reasons for the decisions reached.
Agree. As per 6-5 above.

Local Authorities should be required to ensure that assessments and care plans record, where appropriate, what options have been considered and the reasons for the decisions reached.

Provisional proposal 6-7: under supportive care, a person's care plan must make clear the basis on which their accommodation has been arranged.
Agree. As per above.

Question 6-8: are any changes needed to provide greater protection and certainty for people who lack capacity and their landlords in relation to tenancies?
No comment to make

Question 6-9: what difficulties arise when landlords require tenancies to be signed by a donee or deputy, and how might these be addressed?
No comment to make

Question 6-10: should local authorities and the NHS in England ever set personal budgets for disabled people living at home by reference to the cost of meeting the person's needs in residential care?
No comment to make

Question 6-11: should there be a duty on local authorities and the NHS, when arranging care home, supported living or shared lives accommodation for a person who lacks capacity to decide where to live:
(1) to secure the most appropriate living arrangement for that person, which as far as possible reflects the person's wishes and feelings; and
(2) to seek the agreement of any donee of a Lasting Power of Attorney or deputy, or a declaration from the Court of Protection.
There should always be consideration given to the wishes and feeling of the person when seeking the most appropriate accommodation for that person. To make that a duty should not be onerous and the agreement of a donee or deputy (if there is one) would be appropriate. However, does that mean that where there is no donee or deputy a declaration from the CoP would be required? That would not be viable for a number of reasons, not least cost and expediency.

Question 6-12: should local authorities and the NHS be required to report annually on issues relating to living arrangements and community support, such as the number of living arrangements made and how often these arrangements were inconsistent with the person's wishes and feelings?
No comment to make

Provisional proposal 6-13: all registered care providers should be required to refer an individual for an assessment under the relevant protective care scheme if that person appears to meet the relevant criteria.
Agree.

Question 6-14: should the duty to make referrals for protective care be a regulatory requirement which is enforced by the Care Quality Commission, Care and Social Services Inspectorate Wales, or Healthcare Inspectorate Wales?
Yes. For an external regulatory body such as the CQC to be able to effectively ensure that care providers are providing an acceptable level of care then something as fundamental as whether a person who lacks capacity is receiving all of the relevant safeguards, ie ensuring that referrals are made as and when appropriate, must be a regulatory requirement capable of enforcement.

CHAPTER 7: RESTRICTIVE CARE AND TREATMENT

Provisional Proposal 7-1: the restrictive care and treatment scheme should apply to people who lack decision-making capacity as a result of an impairment of, or a disturbance in the functioning of, the mind or brain.
If interpreting the proposals correctly, RC&T is still relevant only in care homes, ISL and shared lives accommodation and not to a hospital setting?
Agree in relation to restrictive care and treatment. But where that RC&T includes a deprivation of liberty that would lead to a potential incompatibility with Article 5 unless it was being considered that an impairment of, or a disturbance in the functioning of, the mind ***or***

brain *constitutes unsoundness of mind. In some instances there is a 'bright line' distinction between disorders of the mind and disorders of the brain, such as a deprivation of liberty that may arise from an induced coma to manage a traumatic brain injury caused by an accident in someone with no previous history of mental disorder as opposed to a person with a brain injury who has been sedated and coma induced as the brain injury is leading to severe agitation, aggression and personality change (mental disorder). There are few instances where it cannot be argued that a disorder of the brain has given rise to a degree of disorder of the mind and they are generally those identified in the proposals (persistent vegetative state or minimally conscious state caused by a concussion or brain injury, or someone suffering from a stroke or locked in syndrome). In these cases it is also a distinct possibility however, that capacity remains particularly in someone suffering from a stroke or locked in syndrome. It may be preferable in all of these instances that the deprivation of liberty is authorised by a Court, particularly given that this group of people will have inevitably moved to their setting from a hospital setting where it appears there is no regime in place for people who are subject to RC&T unless there is a deprivation of liberty and almost an assumption is drawn that accommodation in a hospital for someone who lacks capacity to consent to it will inevitably be a deprivation of liberty?*

It is very interesting to note that dementia is not mentioned in paragraph 7.4 in relation to the definition of mental disorder even though it is the most common "brain disorder" that exists in the population. There is overwhelming evidence that this should be treated as any other neurological condition and should come under the protective care / restrictive care and treatment focus rather than the Mental Health Act. This would ensure parity of esteem, as well as being a proportionate way of having a legislative protective framework around the individual.

Provisional proposal 7-2: a person would be eligible for safeguards if: they are moving into, or living in, care home, supported living or shared lives accommodation; some form of "restrictive care and treatment" is being proposed; and the person lacks capacity to consent to the care and treatment.
No comment to make.

Provisional proposal 7-3: restrictive care and treatment should include, but should not be limited to, any one of the following:
(1) continuous or complete supervision and control;
(2) the person is not free to leave;
(3) the person either is not allowed, unaccompanied, to leave the premises in which placed (including only being allowed to leave with permission), or is unable, by reason of physical impairment, to leave those premises unassisted;
(4) barriers are used to limit the person to particular areas of the premises;
(5) the person's actions are controlled, whether or not within the premises, by the application of physical force, the use of restraints or (for the purpose of such control) the administering of medication – other than in emergency situations;
(6) any care and treatment that the person objects to (verbally or physically);
(7) significant restrictions over the person's diet, clothing, or contact with and access to the community and individual relatives, carers or friends (including having to ask permission from staff to visit – other than generally applied rules on matters such as visiting hours).

The Secretary of State and Welsh Ministers could add to and amend this list by secondary legislation.

It is at this point that the distinction between a restriction of liberty and a deprivation of liberty now becomes far too blurred. There is a real danger that we go back to the point pre Cheshire West where the definition of a restriction is stretched to a point clearly beyond that which anyone with capacity would consider themselves deprived of liberty. The assumption drawn from the proposals is that if any one of the above is present it is RC&T but if there is the presence of any more than one of the above it has become a deprivation of liberty? This would be complicated to define in practice, for example, if point 3 is present then, almost inevitably, so is point 2, if point 5 is present so is point 1 etc.

In Para 7-31(6) above the concept of care may require expansion. For people who have a dementia a flashpoint can be when a carer is having to help the individual with toileting, washing, bathing, haircut, etc. These interventions by carers are necessary to help support the health and overall dignity of the individual, but the actions of the individual could be regarded as they are objecting to it. Would this require a restrictive care / treatment framework by itself? Similarly a number of people with dementia like to wander and try to leave premises and therefore it is important that the premises have the front door locked so that they are unable to leave. Would this by itself be a sufficient trigger for the restrictive care / treatment framework? In the final proposals, details on this would be welcome.

Question 7-4: should the restrictive care and treatment safeguards be available to people who lack capacity to consent to their care plan, in any of the following cases:
(1) the person is unable, by reason of physical or mental disability, to leave the premises, including:
(a) unable to leave without assistance;
(b) able to leave without assistance but doing so causes the adult significant pain, distress or anxiety;
(c) able to leave without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others; or
(d) able to leave without assistance but takes significantly longer than would normally be expected;
(2) the person has high care needs and consequently is dependent on paid carers; and
(3) the person has limited ability to direct their own care or to access existing safeguards?
Point 1(c) should certainly come within RC&T; the others may depend on the other circumstances of the care arrangements.

Question 7-5: are there any specific forms of care and treatment that should automatically mean that the person is eligible for the restrictive care and treatment safeguards?
In terms of care and treatment there potentially are and examples could include:

- *Medication administered covertly due to objection*
- *Medication administered solely for the purpose of sedation and/or to manage 'behaviour'*
- *Any care or treatment provided under 'restraint' both in terms of the MCA definition and the more generic definition*
- *Being cared for in a single room and physically unable to freely associate with others and/or unable to articulate a desire to associate with others*

There are also potentially any number of environmental/unit regime issues in terms of 'blanket restrictions' such as locked exit doors, locked areas, lack of real choice, set bed times etc which in isolation may not appear overly restrictive but, when there are a number present, cumulatively are.

The administration of prescribed medication as opposed to "over the counter" medication. A wider interpretation could mean the administration of medication that a 'loving relative'

would give as opposed to a sophisticated medication regime which trained healthcare staff would need to give.

Provisional proposal 7-6: the local authority should be required to ensure that an assessment for restrictive care and treatment takes place, and confirm that the restrictive care and treatment is in the person's best interests.
Agree.

Question 7-7: should the restrictive care and treatment assessment require a best interests assessment to determine whether receiving the proposed care or treatment is in a person's best interests, before deciding whether it is necessary to authorise restrictive care and treatment?
Yes. If there is an intention to provide, or provision has already commenced, of care and treatment which is restrictive or intrusive then it must be determined that it is in best interests to provide this level of restrictive and intrusive care and treatment before deciding whether to authorise it.

Question 7-8: should a person be eligible for the restrictive care and treatment scheme if restrictive care and treatment is necessary in their best interests – taking into account not just the prevention of harm to the person but also the risks to others?
This seems to hinge not on RC&T per se but specifically where RC&T includes a deprivation of liberty. In care home, ISL and shared lives settings there is no access to the legislation which is specifically designed to allow a deprivation of liberty (or detention) to protect others from harm – the MHA. Even where the MHA may apply in these settings such as CTOs and Conditional Discharge, there is no provision within that to authorise a deprivation of liberty. It should therefore be possible to authorise RC&T, which may have the effect of preventing harm to others, justified by the oft used argument that if they were to hit someone they would get hit back, therefore we are ultimately preventing harm to them. However, where the RC&T includes a deprivation of liberty this becomes more complex to the point where courts have argued that even where a capable person is consenting to what would be a deprivation of liberty if they lacked capacity, that this should still not be allowed. There is a case due to be reported for the Upper Tribunal very soon around this issue which may provide further clarification but doubtless will still not address the issue of whether a deprivation of liberty can be authorised for someone who lacks capacity, in order to prevent harm to others, in any regime other than the MHA.

Provisional proposal 7-9: cases involving serious medical treatment should be decided by the Court of Protection**.**
Agree.

Question 7-10: should all significant welfare issues where there is a major disagreement be required to be decided by the Court of Protection?
If not, what would be the alternative? There doesn't appear to be one within the proposals and it isn't something else that can fall to the Local Authorities, particularly given that they would be likely to be an involved party.

Provisional proposal 7-11: restrictive care and treatment assessments should be referred to an "Approved Mental Capacity Professional" (currently, the best interests assessor) who would be required to arrange for the assessment to be undertaken by a person already involved in the person's care (eg the person's social worker or nurse) and quality assure the

outcome of that assessment or oversee or facilitate the assessment; or undertake the assessment themselves.
Agree in principle. However, in practice this still requires significant involvement of the AMCP even if they rely on the assessments of others. Where the RC&T includes a deprivation of liberty this should always require an independent assessment. In practical terms then, this will significantly increase the workload of the AMCP if they must have a level of involvement in all assessments for RC&T, even where a deprivation of liberty is not present, and, as suggested in our response, carry out the independent assessment where there is a deprivation of liberty. Without this independent assessment for a deprivation of liberty to be agreed where is the safeguard for the person other than the right to appeal once the deprivation of liberty is underway? The right of appeal is envisaged to be similar to that of a person detained under the MHA, ie to a FTT, but even then, the initial detention under the MHA must include the independent assessment of the AMHP and take into account to conflict of interest regulations.

Provisional proposal 7-12: the "Approved Mental Capacity Professional" (currently, the Best Interests Assessor) would be required to specify the duration of restrictive care and treatment, which may not exceed 12 months.
Given the level of responsibility placed on the AMCP in the rest of the process it would seem sensible to allow them to determine the duration of RC&T which they have determined as necessary.

Provisional proposal 7-13: the Secretary of State and Welsh Ministers should have powers in secondary legislation to provide for equivalent assessments, timescales for the completion of assessments and records of assessments.
Agree.

Question 7-14: what should the timescales be for the assessments under protective care and what records should be contained in the assessment?
Ideally anybody entering into 'Protective care', whether it be 'Supportive care' or' RC&T' should have the necessity for it agreed in advance of it commencing. Given that at this point we are only talking about a move into a care home, ISL or shared lives accommodation this should not, in most circumstances, be an 'emergency' move but there are instances where it could be such a sudden breakdown carer arrangements for someone being cared for at home. The current timescale of 'any time within the next 28 days' should be sufficient time to plan ahead and complete assessments, particularly where the assessments are being conducted by a person already involved in planning the care.

Provisional proposal 7-15: restrictive care and treatment should enable Approved Mental Capacity Professionals (currently, Best Interests Assessors) to use equivalent assessments where this is necessary.
Until the required assessments are agreed it is difficult to comment whether the use of equivalent assessments should be available.

Provisional proposal 7-16: the new scheme should establish that the "Approved Mental Capacity Professional" (currently, the Best Interests Assessor) acts on behalf of the local authority but as an independent decision-maker. The local authority would be required to ensure that applications for protective care appear to be duly made and founded on the necessary assessment.
No comment to make.

Provisional proposal 7-17: the Health and Care Professions Council and Care Council for Wales should be required to set the standards for, and approve, the education, training and experience of "Approved Mental Capacity Professionals" (currently, Best Interests Assessors).
No comment to make.

Provisional proposal 7-18: the ability to practise as an "Approved Mental Capacity Professional" (currently, the Best Interests Assessor) or Approved Mental Health Professional should be indicated on the relevant register for the health or social care professional.
No comment to make.

Question 7-19: should there be additional oversight of the role of the "Approved Mental Capacity Professional" (currently, the Best Interests Assessor) and a right to request an alternative assessment?
No comment to make.

Provisional proposal 7-20: the "Approved Mental Capacity Professional" (currently, the Best Interests Assessor) should be responsible for setting conditions and making recommendations in respect of the person's care and treatment.
It may not be appropriate for a best interest assessor to make recommendations for a more restrictive application than the opinion of an expert Consultant Psychiatrist, or other expert mental health professional that is involved in the decision making. They might have a role in determining a less restrictive regime but certainly not a more restrictive regime.

Provisional proposal 7-21: the "Approved Mental Capacity Professional" (currently, the Best Interests Assessor) should be given responsibility for monitoring compliance with conditions. This could be delegated to health and social care professionals who are allocated to the case, and advocates and the appropriate person would be required to report any concerns about noncompliance with conditions.
No comment to make.

Question 7-22: should the new scheme allow for conditions or recommendations to be made that are more restrictive of liberty than the application is asking for?
No comment to make.

Question 7-23: should there be specific sanctions for a failure to comply with a condition, and if so, what should they be?
No comment to make.

Provisional proposal 7-24: an "Approved Mental Capacity Professional" (currently, the Best Interests Assessor) should be allocated to every person subject to the restrictive care and treatment scheme. This should not be the same professional who authorised the restrictive care and treatment.
No comment to make.

Provisional proposal 7-25: the "Approved Mental Capacity Professional" (currently, the Best Interests Assessor) should be required to keep under review generally the person's

care and treatment, and given discretion to discharge the person from the restrictive care and treatment scheme.
No comment to make.

Provisional proposal 7-26: the "Approved Mental Capacity Professional" (currently, the Best Interests Assessor) should be able to review and vary conditions without necessarily holding a full reassessment of best interests.
No comment to make.

Provisional proposal 7-27: the local authority should be given general discretion to discharge the person from the restrictive care and treatment scheme. Local authorities could consider discharge themselves, or arrange for their power to be exercised by a panel or other person.
No comment to make.

Provisional proposal 7-28: the "Approved Mental Capacity Professional" (currently, the Best Interests Assessor) and local authority must review the care and treatment following a reasonable request by the person, a family member or carer, or an advocate or appropriate person.
No comment to make.

Provisional proposal 7-29: if a person who is eligible for the restrictive care and treatment scheme needs to be deprived of liberty in his or her best interests, this must be expressly authorised by the care plan.
Agree.

Provisional proposal 7-30: cases of deprivation of liberty concerning those living in a family or domestic setting must be authorised by the Approved Mental Capacity Professional and subject to the same safeguards as those provided under the restrictive care and treatment scheme.
No comment to make.

Provisional proposal 7-31: the Approved Mental Capacity Professional (currently the Best Interests Assessor) should ensure that before a deprivation of liberty is authorised, objective medical evidence be provided by a doctor or psychologist who is independent of the detaining institution. If appropriate evidence already exists, a fresh assessment should not be required.
Agree that the medical evidence should be independent and the existence of appropriate evidence must also be from an independent source in the absence of a fresh assessment.

Provisional proposal 7-32: the medical assessment should confirm that the person is suffering from a disability or disorder of mind or brain and lacks capacity to consent to the proposed care and treatment**.**
Same issue as at 7.1 above – does a disorder of the brain alone sufficiently satisfy Article 5 requirements in terms of a deprivation of liberty?

Question 7-33: should the medical assessment address other matters such as providing a second opinion on treatment already being provided or proposed?
That would be wholly dependent on the experience and expertise of the medical assessor in relation to the care and treatment being provided or proposed.

Question 7-34: should doctors be eligible to act as Approved Mental Capacity Assessors (currently Best Interests Assessors)?
Currently Mental Health Assessors can act as capacity assessors under DoLS, this is not reserved to the BIA.

Provisional proposal 7-35: an Approved Mental Capacity Professional (currently Best Interests Assessor) should be able to authorise restrictive care and treatment in urgent cases for up to 7 days, and to extend this period once for a further 7 days, pending a full assessment.
Agree.

Provisional proposal 7-36: the restrictive care and treatment scheme should include powers to authorise transportation, leave, suspension and transfers. It should also enable care and treatment to be authorised in multiple settings.
Agree.

CHAPTER 8: PROTECTIVE CARE IN HOSPITAL SETTINGS AND PALLIATIVE CARE

Provisional proposal 8-1: a separate scheme should be established for hospitals and palliative care settings.
Agree.

Provisional proposal 8-2: a person may be deprived of liberty for up to 28 days in a hospital setting based on the report of a registered medical practitioner. A responsible clinician must be appointed and a care plan produced. Further authorisations for a deprivation of liberty would require the agreement of an Approved Mental Capacity Professional (currently a Best Interests Assessor).
From the proposals it is clear that in a hospital or palliative care setting, protective care safeguards only 'kick in' where there is a deprivation of liberty or the potential for it. Once again, in the absence of the requirement for the presence a mental disorder, using a lack of capacity to consent to the care or treatment alone as the marker could lead to a potential incompatibility with Article 5 unless it is being considered that an impairment of, or a disturbance in the functioning of, the mind ***or brain alone*** *constitutes unsoundness of mind? If so, this may be appropriate potentially for minimally conscious or PVS or locked in patients where there may well not be a mental disorder present, or the presence or otherwise is unknown, but there are a significant number of people in acute hospital settings who lack capacity as the direct result of mental disorder which may or may not be transient and may or may not arise from the physical healthcare issue itself, eg the delirious patient, patient with dementia, learning disability patient, acute alcohol withdrawal etc. Is there a possibility of leaving the presence of mental disorder requirement in place in order to satisfy Article 5 and then consider further what may be required for the incapable people who are rendered such as a result of an impairment or disturbance in the functioning of their brain alone, however acquired?*

Of course, the MHA is also available to people in acute hospitals and it may be that this is a more appropriate response where the need to deprive of liberty is arising primarily from the mental disorder rather than the physical problem. Key examples of this are delirium, acute alcohol withdrawal and treatment of self-inflicted injuries, as opposed to a deprivation necessary to treat, for example, a fractured neck of femur in a person lacking capacity to

consent to the care and treatment due to dementia who in the absence of the fracture could go home. The proposals also suggest that it only becomes a deprivation of liberty when the person actually asks or attempts to leave or another person asks or attempts to remove them. This does seem to water down the acid test somewhat rather than 'elaborate' it so that the compliant incapable person is not deprived of liberty despite the fact that they would be prevented from leaving if they so expressed the wish, almost relying on the premise of 'they would consent if they could'. So the question is – in an acute hospital setting where the person is receiving treatment in best interests and is fully compliant, there will be no deprivation of liberty unless they ask to leave or another person asks to remove them? This does not comply with the acid test but would solve a significant problem currently faced by acute hospitals.

Interpretation of the proposals suggests that a different doctor other than the treating doctor who becomes the 'responsible clinician' (must be careful to avoid confusion with RC under the MHA) would be required to certify in writing that the conditions are met. Who would this doctor be? Would they be required to have any experience in terms of mental disorder (such as the current Mental Health Assessors under DoLS) if the suggestions above that mental disorder should still be present is accepted? This would also provide a level of independence medically and the backlog with DoLS authorisations currently does not appear to be due to a shortage of MH Assessors. Who would be anticipated to take on the role of the Hospital Managers, is it the same in terms of Hospital Managers under the MHA? Would there need to be a role similar to that of MHA admin staff to manage authorisations in acute hospital settings? This proposal looks like a mini mental health act but without the need for the presence of mental disorder.

Question 8-3: is the appointment of an advocate always appropriate in all hospital cases, or is there a need for an alternative safeguard (such as a second medical opinion)?
If the first medical opinion is provided by an independent doctor, such as the current MH Assessor, as suggested above then this may be an additional sufficient safeguard for the initial 28 days. However, for a person deprived of their liberty there should still also be an advocate appointed.

CHAPTER 9: ADVOCACY AND THE RELEVANT PERSON'S REPRESENTATIVE

Provisional proposal 9-1: an independent advocate or an appropriate person must be appointed for any individual subject to protective care. The individual must consent to such support or if the individual lacks capacity to consent, it must be in their best interests to receive such support.
Agree.

Provisional proposal 9-2: the provision of advocacy should be streamlined and consolidated across the Care Act and Mental Capacity Act (in its entirety), so that Independent Mental Capacity Advocates would be replaced by a system of Care Act advocacy and appropriate persons.
There are very clear crossovers in terms of advocacy currently with IMCAs, IMHAs, Care Act advocates etc and it would be useful to streamline Advocacy services but whilst preserving the specific skills that have been developed over time to avoid making advocacy too 'generic' in nature.

Question 9-3: should the appropriate person have similar rights to advocates under the Care Act to access a person's medical records?
No comment to make.

Question 9-4: should Independent Mental Health Advocacy be replaced by a system of Care Act advocacy and appropriate persons?
As 9.2 above.

Provisional proposal 9-5: a "relevant person's representative" should be appointed for any person subject to the restrictive care and treatment scheme (or the hospital scheme) and who is being represented by an advocate. The person must consent to being represented by the representative, or if they lack capacity to consent, it must be in the person's best interests to be represented by the representative.
No comment to make.

Provisional proposal 9-6: where there is no suitable person to be appointed as the representative, the person should be supported by an advocate or appropriate person.
No comment to make.

Provisional proposal 9-7: the Approved Mental Capacity Professional (currently Best Interests Assessor) should have discretion to appoint a representative where the person is being supported by an appropriate person.
No comment to make.

Provisional proposal 9-8: the Approved Mental Capacity Professional (currently best interests assessor) should be required to monitor the relevant person's representative and ensure they are maintaining contact with the person.
No comment to make.

Question 9-9: does the role of relevant person's representative need any additional powers?
No comment to make.

Consultation question 9-10: should people always where possible be provided with an advocate and a relevant person's representative, and could these roles be streamlined?
No comment to make.

CHAPTER 10: THE MENTAL HEALTH ACT INTERFACE

Provisional proposal 10-1: the Mental Health Act should be amended to establish a formal process for the admission of people who lack capacity and who are not objecting to their care and treatment. The safeguards provided would include an independent advocate, a requirement for a second medical opinion for certain treatments and rights to appeal to the mental health tribunal. The Mental Capacity Act (and our new scheme) could not be used to authorise the hospital admission of incapacitated people who require treatment for mental disorder.
Firstly, from the perspective of a very large specialist MH and LD provider Trust there are very few people who currently genuinely meet the criteria for the use of DoLS in a mental health in-patient setting, ie within the scope of the MHA ***and wholly compliant.***

For as long as mental health and social care professionals, legal services, advocacy services etc continue to talk about the MHA and associate it with stigma, that will continue to be the perception. There is a clear need to set out and promote the MHA as an Act which provides well defined and well understood and tested safeguards to those comparatively small number of people who ***require*** *to be admitted to hospital for medical treatment of their mental disorder with a subsequent deprivation of their liberty (or detention, in the case of a capable person). The purpose of admission is to provide medical treatment in terms of the definition set out in section 145, not always in the form of medication, but to treat nonetheless, either with or without consent. The provision of treatment in the form of medication (as well as ECT and psychosurgery) carries additional safeguards, particularly where the person refuses to or cannot consent. As set out earlier in your proposals, the MHA provides a power not a duty to deprive of liberty (admit), it also provides a power not a duty to treat with medication.*

There is a concern that introducing a new MHA process to 'water down' the MHA to make it more palatable and less 'stigmatising' could succeed in reducing the available safeguards whilst still 'sectioning' people under its powers and it is questionable what is the gain from that. If it is explained to relatives, carers and service users correctly that a compliant incapable person needs to be in hospital to receive treatment and everybody is in agreement with that, then the next step is to explain that because the person cannot consent to the arrangements then it is necessary to put significant safeguards and rights in place, both for them and their relatives, and those safeguards and rights are to be found in the MHA. It must be acknowledged however that there a number of different views expressed around this and it is accepted that relatives often find the use of the MHA in such circumstances difficult and stigmatising especially in relation to those suffering from dementia. The content of paragraph 5.26 does not appear to be consistent with Lady Hales' argument that people with a 'disability' should not be treated differently to those who have not. Many people with serious mental illness would classify themselves as having a disability because of that illness and especially so with the impact of dementia.

The concept of 'objection' is a difficult concept in the context of people who have dementia or who have a profound learning disability. The typical objection people have who suffer from dementia is exactly the same type of objection as they have when in a nursing home or care home i.e. they want to wander and often want to leave the premises and also object to a carer attending to matters of personal hygiene. They may also object to taking medication, irrespective of whether it is psychiatric medication or any other type. Because a person with dementia is in a designated dementia ward in a mental health facility this should not require them to be placed under the Mental Health Act when, if they were in a nursing home, they would be placed under the protective care framework. Again the key principle here should be parity of esteem and we would suggest that dementia should be regarded as a neurological brain disorder as opposed to a mental illness for the purpose of recalibrating the Mental Health Act and the protective care framework.

It appears that the right to independent advocacy, a second opinion for certain treatments and the right to appeal to the Mental Health Tribunal, as described within the proposals, mirror what is already available within the MHA. If the intention of the introduction of an amended MHA section in circumstances of incapacitated compliance is to remove automatic eligibility to section 117 After-care, which is not explicitly referenced within the proposals, then that would have a significant impact. From the perspective of families this may well be seen as having a negative impact due to the funding of aftercare, however from

a hospital provider perspective, the current issues and delays associated with agreeing placements and associated funding which can lead to significant delays in discharge from hospital to a care placement would be ameliorated.

*A preferred proposal would be that any person who requires admission to hospital for treatment of mental disorder (ie meets the criteria), in the absence of their capable consent, will be admitted subject to the MHA (as it currently exists) in order to ensure that they are afforded **all** of the safeguards set out in the MHA. This removes any ambiguity about which regime to choose and ensures equity in terms of safeguards. Just because somebody is incapable but compliant should not mean that they are afforded less safeguards than a non-compliant person. This should also be the case for admission to acute hospital settings where the primary purpose of admission is to treat physical consequences of mental disorder (ie symptoms and manifestations) eg, treatment of overdose, re-feeding in anorexia etc.*

The alternative is to argue that there is a much clearer push (in law) to use the replacement for DoLS – the Restrictive Care and Treatment regime (which does not have the stigma of MHA and gives no S117 aftercare rights) for non-objecting non-capacitious admissions to mental health hospitals.

CHAPTER 11: RIGHT TO APPEAL

Provisional proposal 11-1: there should be a right to apply to the First-tier Tribunal to review cases under our restrictive care and treatment scheme (and in respect of the hospital scheme), with a further right of appeal.
Certainly where the RC&T scheme includes a deprivation of liberty there must be a right of appeal to remain Article 5(4) compliant, the same for the hospital scheme which is only used to authorise a deprivation of liberty. Whether the FTT is the correct route of appeal will require further consideration but it would appear to already have the infrastructure and experience necessary to consider this kind of appeal.

Provisional proposal 11-2: an appeal against the decision of the First-tier Tribunal should lie on points of law in all cases and on law and fact where the issues raised are of particular significance to the person concerned.
Agree.

Question 11-3: which types of cases might be considered generally to be of "particular significance to the person concerned" for the purposes of the right to appeal against the decision of the First-tier Tribunal?
No comment to make.

Provisional proposal 11-4: local authorities should be required to refer people subject to the restrictive care and treatment scheme (or the hospital scheme) to the First-tier Tribunal if there has been no application made to the tribunal within a specified period of time.
Agree.

Question 11-5: in cases where there has been no application made to the First tier Tribunal, what should be the specified period of time after which an automatic referral should be made?

The same provisions available within the MHA would seem reasonable, ie after 6 months initially and then 3 years after that.

Question 11-6: how might the First-tier Tribunal secure greater efficiencies – for example, should paper reviews or single member tribunals be used for relatively straightforward cases?
No comment to make.

Question 11-7: what particular difficulties arise in court cases that raise both public and private law issues, and can changes to the law help to address these difficulties?
No comment to make.

Question 11-8: should protective care provide for greater use of mediation and, if so, at what stage?
No comment to make.

Question 11-9: what are the key issues for legal aid as a result of our reforms?
No comment to make.

CHAPTER 12: SUPPORTED DECISION-MAKING AND BEST INTERESTS

Provisional proposal 12-1: a new legal process should be established under which a person can appoint a supporter in order to assist them with decision-making. The supporter must be able, willing and suitable to perform this role. The Approved Mental Capacity Professional (currently best interests assessor) would be given the power to displace the supporter if necessary (subject to a right of appeal).
No comment to make.

Provisional proposal 12-2: section 4 of the Mental Capacity Act should be amended to establish that decision-makers should begin with the assumption that the person's past and present wishes and feelings should be determinative of the best interests decision.
No comment to make.

CHAPTER 13: ADVANCE DECISION-MAKING

Provisional proposal 13-1: the ability to consent to a future deprivation of liberty should be given statutory recognition. The advance consent would apply as long as the person has made an informed decision and the circumstances do not then change materially.
Agree insofar as it is set out within the proposals, ie that it already applies in terms of consent to a surgical procedure that carries forward even when the person is rendered incapable by the administration of an anaesthetic. The ability to consent in advance to a deprivation of liberty in terms of end of life and palliative care may also require further consideration where the material circumstances of the consent do not change and significant unanticipated restrictions are not applied. The current DoLS process in terms of end of life and palliative care places significant additional pressure on the families and carers of those about to die. It also creates significant issues, distress and unnecessary bureaucracy in terms of Coroners activity following death 'in custody' where the death is completely expected and everyone, including the person themselves, has agreed to the end of life care proposed even though it will amount to a deprivation of liberty once capacity is lost.

Provisional proposal 13-2: the restrictive care and treatment scheme and the hospital scheme would not apply in cases where they would conflict with a valid decision of a donee or advance decision.
It couldn't apply, otherwise you would effectively be seeking to have RC&T agreed to provide treatment that there is no lawful authority to give.

Question 13-3: how (if at all) should the law promote greater use of advance decision-making?
No comment to make.

CHAPTER 14: REGULATION AND MONITORING

Provisional proposal 14-1: the Care Quality Commission, Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales should be required to monitor and report on compliance with the restrictive care and treatment scheme and the hospital scheme.
Agree.

Question 14-2: how might the new legal framework encourage greater joint working between the various health and social care bodies and regulatory schemes and alternative forms of regulation?
No comment to make.

Question 14-3: is greater regulatory oversight needed of individual decision makers and local authorities and the NHS for the purposes of protective care?
No comment to make.

CHAPTER 15: OTHER ISSUES

Provisional proposal 15-1: protective care should apply to persons aged 16 and over.
No comment to make.

Question 15-2: is the concept of the zone of parental responsibility appropriate in practice when applied to 16 and 17 year olds who lack capacity?
No comment to make.

Question 15-3: what are the current difficulties that arise when identifying the supervisory body for the purposes of the DoLS? Are there any current areas that could be usefully clarified under the new scheme?
No comment to make.

Question 15-4: is a fast track determination scheme needed for cases where a person is deprived of liberty and there is a dispute over the person's ordinary residence?
No comment to make.

Question 15-5: should a new criminal offence of unlawful deprivation of liberty be introduced?
No comment to make.

Provisional proposal 15-6: the Criminal Justice Act 2009 should be amended to provide that inquests are only necessary into deaths of people subject to the restrictive care and treatment scheme where the coroner is satisfied that they were deprived of their liberty at the time of their death and that there is a duty under article 2 to investigate the circumstances of that individual's death.
No comment to make.

Question 15-7: should coroners have a power to release the deceased's body for burial or cremation before the conclusion of an investigation or inquest?
No comment to make.

Question 15-8: is the current law on the reporting of deaths to the coroners satisfactory?
Not really. Although national guidance has been issued it is still left to individual Coroners to decide how it should be interpreted in practice.

Question 15-9: should people be charged for their accommodation when they are being deprived of liberty in their best interests – and are there any realistic ways of dealing with the resource consequences if they are not charged?
No comment to make.

Question 15-10: does the law concerning foreign detention orders cause difficulties in practice?
No comment to make.

Question 15-11: what difficulties arise when a person needs to be deprived of liberty and has been placed by a local authority in England or Wales into residential care in a different UK country?
No comment to make.

ITEM 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date: **27 October 2015**

Title: **Finance Report for Period 1 April 2015 to 30 September 2015**

Lead Director: **Colin Martin, Director of Finance**

Report for: **Assurance and Information**

This report includes/supports the following areas:

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

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

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

BOARD OF DIRECTORS

Date of Meeting: **27 October 2015**

Title: **Finance Report for period 1 April 2015 to 30 September 2015**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2015 to 30 September 2015.

2. BACKGROUND INFORMATION

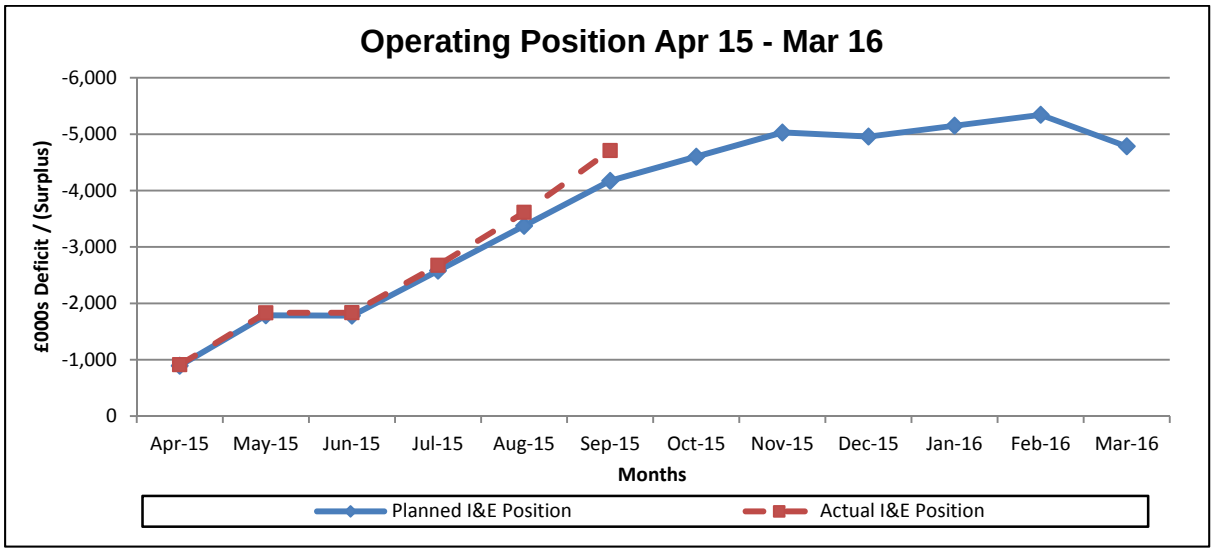
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

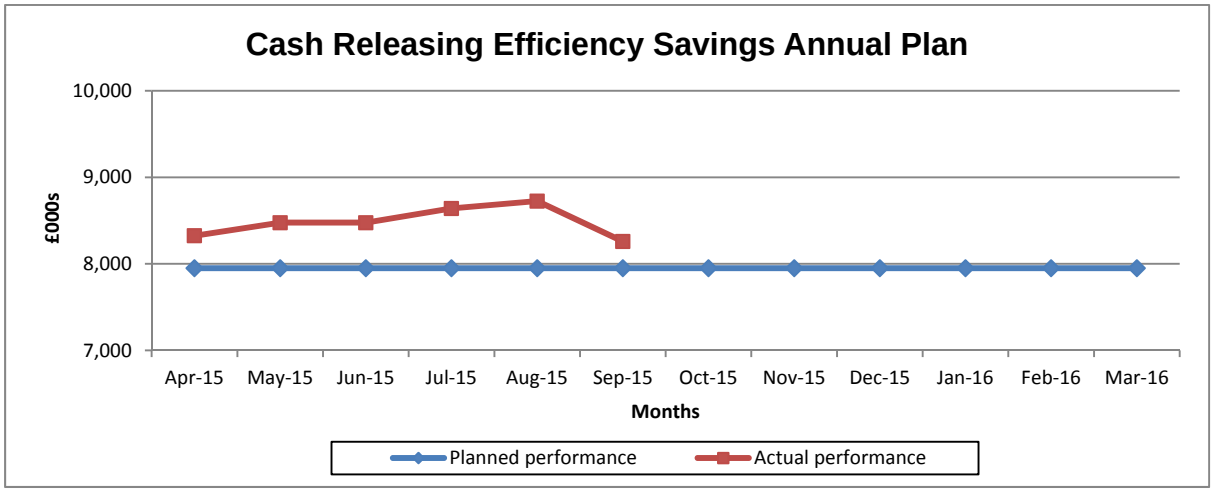
The financial position shows a surplus of £4,711k for the period 1 April 2015 to 30 September 2015, representing 3.3% of the Trust's turnover and is ahead of plan.

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

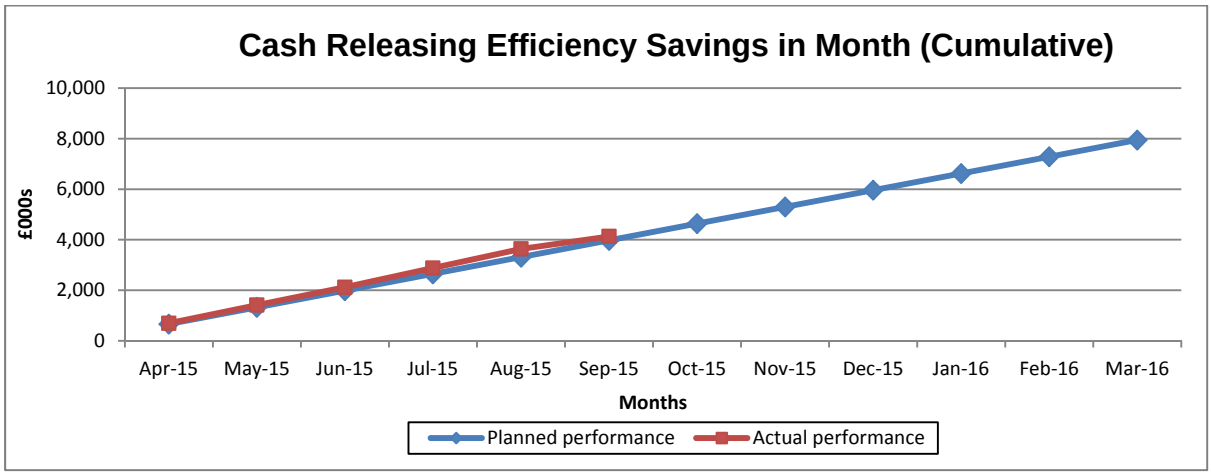


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 30 September 2015 is £8,259k. The decline in September is due to a number of schemes that have been deferred to 2016/17; however, the Trust remains £310k ahead of plan.

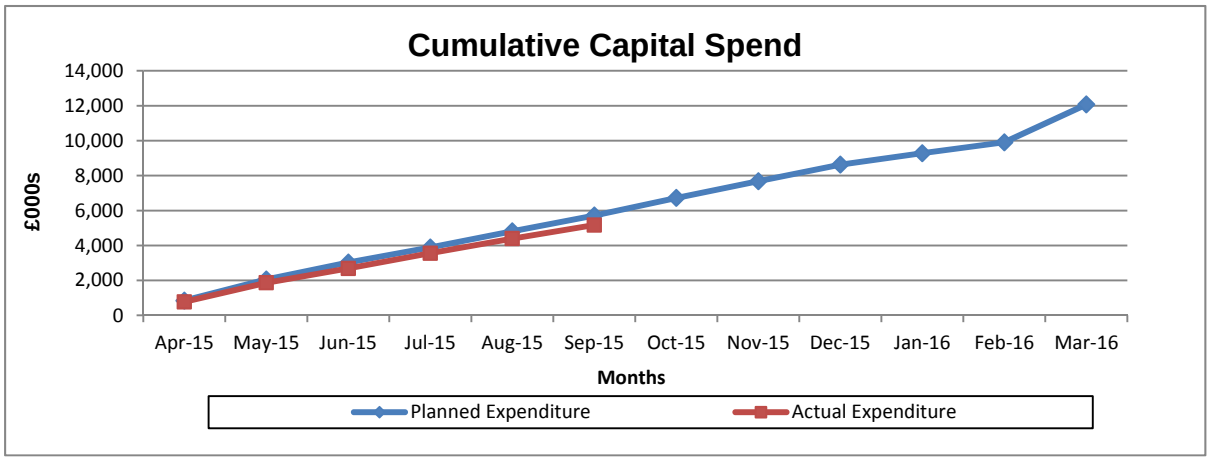


The monthly profile for CRES identified by Localities is shown below.



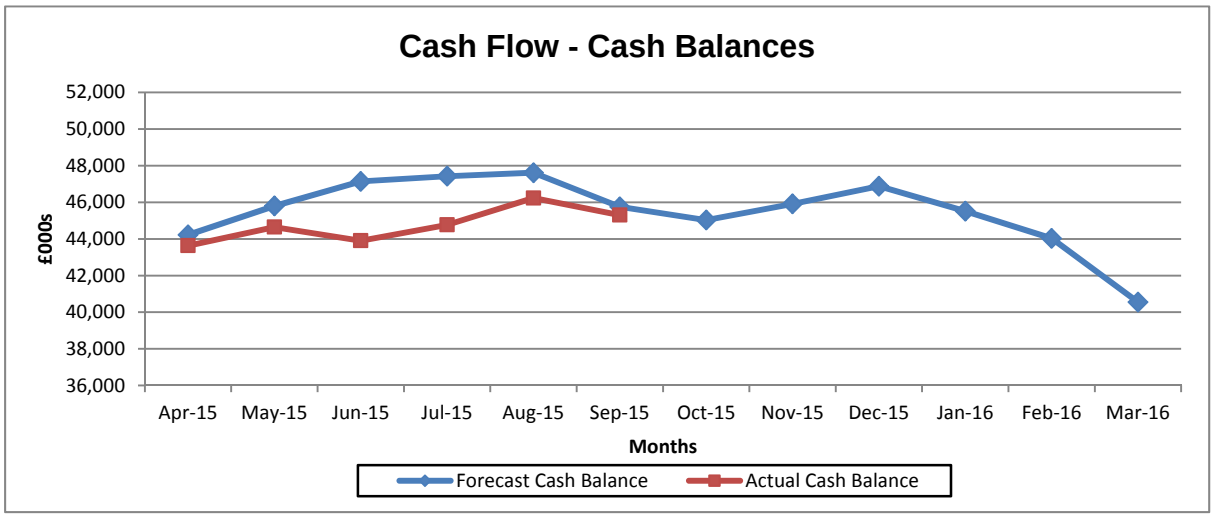
3.3 Capital Programme

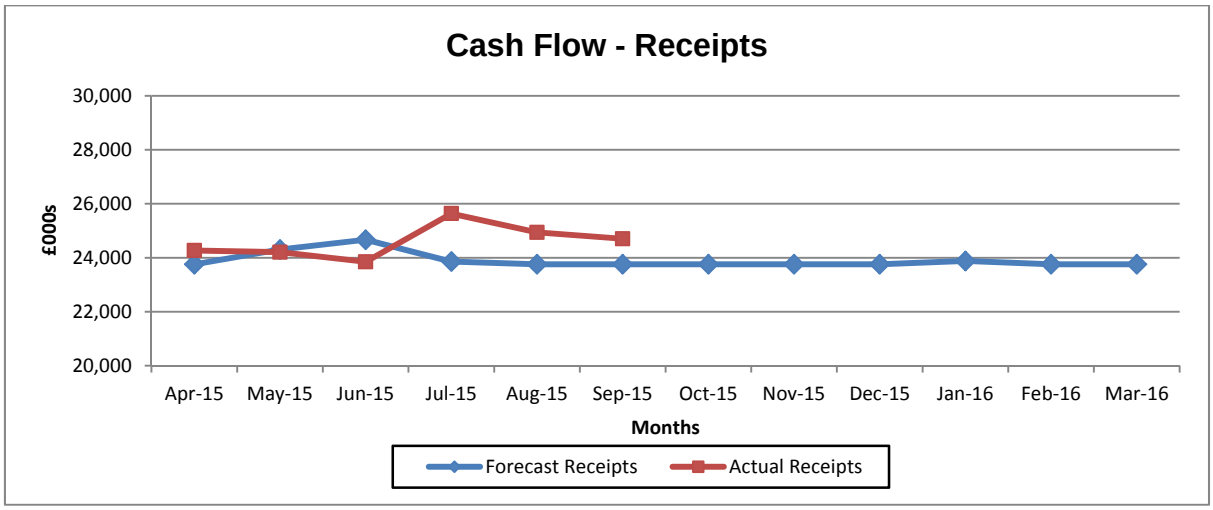
Capital expenditure to 30 September 2015 is £5,171k, which is marginally behind plan.

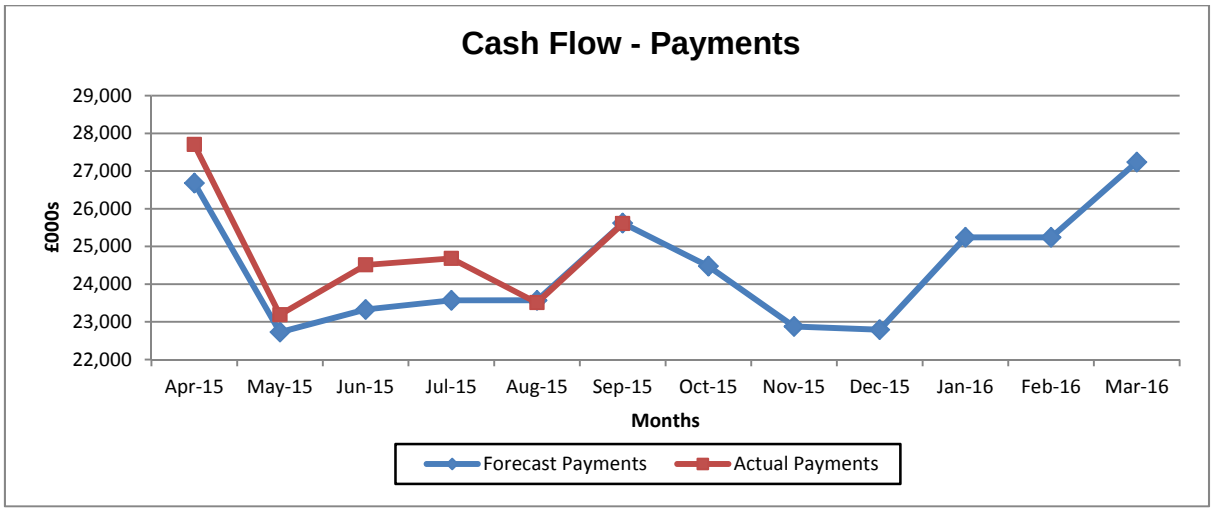


3.4 Cash Flow

Total cash at 30 September 2015 is £45,302k and is in line with plan.



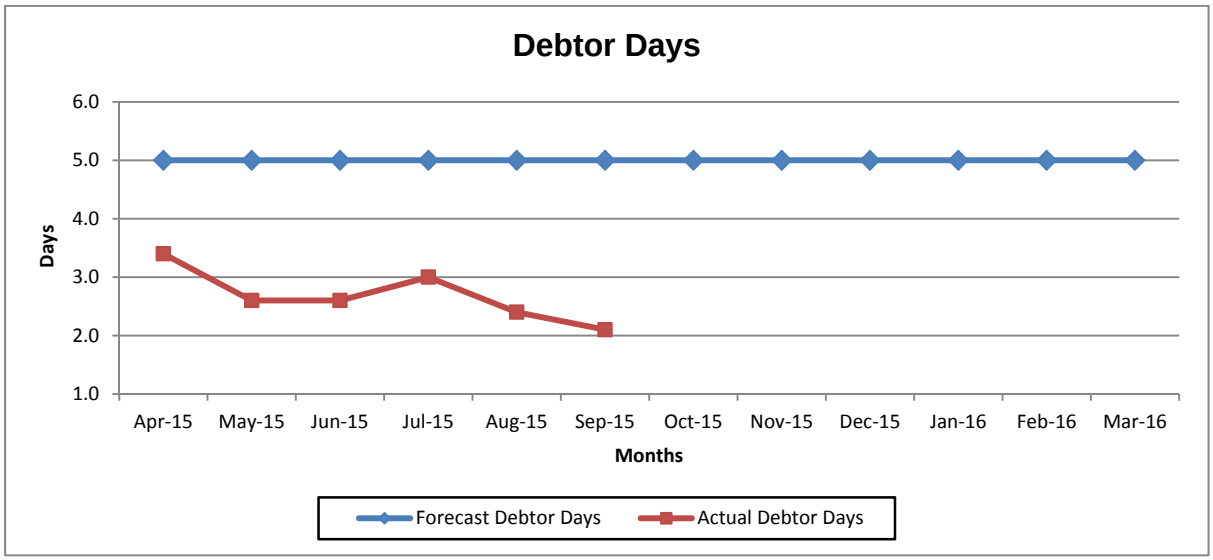




The payments profile fluctuates over the year for PDC dividend payments, financing repayments and payments for capital expenditure.

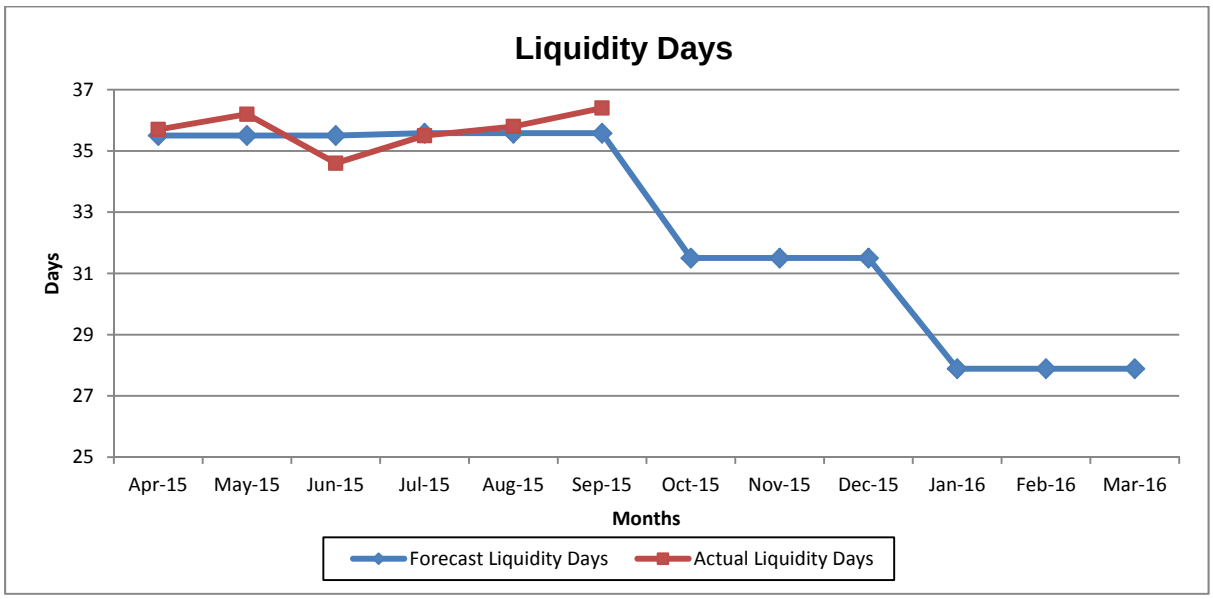
Working Capital ratios for period to 30 September 2015 were:

- Debtor Days of 2.1 days
- Liquidity of 36.4 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 85.23%
  Non NHS 30 Days – 98.14%



The Trust had a debtors' target of 5.0 days and actual performance of 2.1 days, which is ahead of plan.

3.4.1 The liquidity days graph below reflects the metric within Monitor's risk assessment framework. The Trust liquidity day's ratio is marginally ahead of plan.



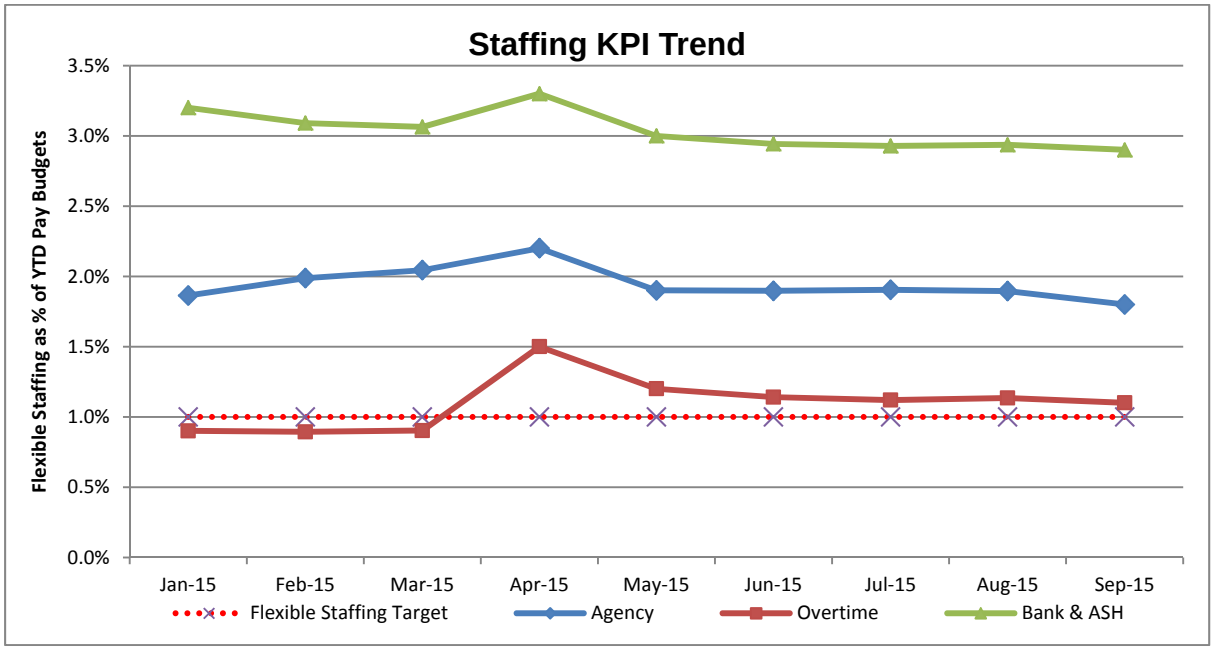
3.5 Financial Drivers

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

Tolerance	May	Jun	Jul	Aug	Sep
Agency (1%)	1.9%	1.9%	1.9%	1.9%	1.8%
Overtime (1%)	1.2%	1.1%	1.1%	1.1%	1.1%
Bank & ASH (flexed against establishment)	3.0%	2.9%	2.9%	2.9%	2.9%
Establishment (90%-95%)	94.1%	93.7%	94.0%	94.3%	94.0%
Total	**100.2%**	**99.7%**	**100.0%**	**100.3%**	**99.8%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for Agency and Overtime, and flexed in correlation to staff in post for Bank & ASH. For September 2015 the tolerance for Bank and ASH is 4.0% of pay budgets.

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



Additional staffing expenditure is 5.8% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (44%), enhanced observations (20%) and sickness (17%).

3.6 Monitor Risk Ratings and Indicators

3.6.1 Monitor introduced a revised Financial Sustainability Risk Rating framework from August which incorporates the CoSRR ratings and two further ratings:

- income and expenditure margin;
- variance from plan in relation to I&E margin.

For consistency the Trust will continue to report both ratings for September.

The Continuity of Service Risk Rating was assessed as 3 at 30 September 2015 and is in line with plan.

The Financial Sustainability Risk Rating was assessed as 4 at 30 September 2015, and is in line with the restated planned risk rating.

3.6.2 Capital service capacity rating (named "Debt service cover" under previous risk rating) assesses the level of operating surplus generated, to ensure a Trust is able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.63x (can cover debt payments due 1.63 times), which is in line with plan and is rated as a 2 in both ratings.

3.6.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 36.4 days which is in line with plan and is rated as a 4 in both ratings.

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 3.8% and is rated as a 4.

3.6.5 The variance from plan assesses the level of surplus or deficit against plan, excluding exceptional items e.g. impairments. The Trust surplus is 0.2% ahead of plan and is rated as a 4.

3.6.6 The margins on Financial Sustainability Risk Rating are as follows:

- Capital service cover - to reduce to a 1 a surplus decrease of £2,778k is required.
- Liquidity - to reduce to a 3 a working capital reduction of £26,539k is required.
- I&E Margin – to reduce to a 3 an operating surplus decrease of £5,386k is required.
- Variance from plan – to reduce to a 3 an operating surplus decrease of £322k is required.

Monitors Rating Guide	**Weighting**	**Rating Categories**			
	%	**4**	**3**	**2**	**1**
Capital service Cover	25	2.50	1.75	1.25	<1.25
Liquidity	25	0.0	-7.0	-14.0	<-14
I&E Margin	25	1%	0%	-1%	<=-1%
Variance from plan	25	0%	-1%	-2%	<=-2%

TEWV Performance	**Actual**		**Annual Plan**		**RAG**
	Achieved	Rating	Planned	Rating	**Rating**
Capital service Cover	1.63x	2	1.58x	2	
Liquidity	36.4 days	4	35.6 days	4	
I&E Margin	3.8%	4	3.6%	4	
Variance from plan	0.2%	4	0%	4	

Overall Financial Sustainability Risk Rating	**4.00**

3.6.7 5.7% of total receivables (£131k) are over 90 days past their due date. This is marginally above the 5% finance risk tolerance set by Monitor, but is not a cause for concern.

3.6.8 2.0% of total payables invoices (£187k) held for payment are over 90 days past their due date. This is within the 5% finance risk tolerance set by Monitor.

3.6.9 The cash balance at 30 September 2015 is £45,302k and represents 63.1 days of annualised operating expenses.

3.6.10 Actual capital expenditure is 90% of planned expenditure to date.

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

4. IMPLICATIONS / RISKS

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

5. CONCLUSIONS

5.1 The comprehensive income outturn for the period ending 30 September 2015 is a surplus of £4,711k, which is equivalent to 3.3% of turnover and is marginally ahead of plan.

5.2 Identified Cash Releasing Efficiency Savings at 30 September 2015 have reduced as some schemes have been deferred into 2016/17. Mitigating schemes are being developed to manage the effect of this shortfall in 2015/16.

The Trust continues to identify schemes to deliver CRES in 2016/17 whilst plans continue to be progressed for 2017/18.

5.3 The Continuity of Services Risk Rating for the Trust is 3 for the period ending 30 September 2015.

5.4 The Financial Sustainability Risk Rating for the Trust is 4 for the period ending 30 September 2015.

6 RECOMMENDATIONS

6.1 The Board of Directors are requested to receive the report, to note the conclusions in section 5 and to raise any issues of concern, clarification or interest.

6.2 The Board of Directors are requested to approve the signing of the In Year Governance Statement confirming maintaining a financial sustainability risk rating of at least 3 in the next 12 months.

6.3 The Board of Directors are requested to approve the signing of the In Year Governance Statement confirming capital expenditure for the remainder of the financial year will not materially differ from plan. .

Colin Martin
Director of Finance

Item 12

BOARD OF DIRECTORS

Date of Meeting: **27th October 2015**

Title: **Board Dashboard as at 30th September 2015**

Lead Director: **Sharon Pickering, Director of Planning, Performance & Communications**

Report for: **Assurance**

This report includes/supports the following areas:

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

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

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

BOARD OF DIRECTORS

Date of Meeting: **27th October 2015**

Title: **Board Dashboard as at 30th September 2015**

1 INTRODUCTION & PURPOSE

1.1 To present to the Board the Trust Dashboard **(Appendix 1)** as at 30th September 2015 in order to identify any significant risks to the organisation in terms of operational delivery.

2. KEY RISKS/ISSUES

2.1 Key Issues/Risks

The key issues are as follows:

- 10 of the 24 (42%) indicators are being reported as red in September 2015 which is the same position as in August 2015. Of those 10, only 1 is showing an improving trend over the last 3 months.

The key risks are as follows:

- Access - Both waiting time targets (KPIs 1 & 2) continue to show an underperformance as at the end of September. Following the improvement in KPI 1(external referrals) during August performance has reduced in September however the three month trend is still one of improvement. The action plans developed by the services are continuing to be implemented and a detailed update against the Trust wide action plan will be presented to the Board in November 2015. Children and Young Peoples' services continue to be the area of most concern however the number of CYP still waiting over 4 weeks at the end of September has reduced slightly compared to August. KPI2 (internal referrals) has declined in September.

- Psychological Therapies

  18 Week Waiting Time (KPI 5) – We continue to report under target for this indicator and have seen a further decline in performance in September. The Teesside locality is the service furthest away from target however it is expected that this will improve as a consequence of resources being moved from carrying out assessments to providing treatment over the coming months. In North Yorkshire the particular issue relates to waiting times for Step 3 treatment and the service are already taking action to address this in addition to identifying further actions that can be put in place.

Access (KPI 6) - performance has improved significantly in September and is higher than the same period in September 2014 and September 2013. Furthermore whilst the 3 month trend is one of deterioration the overall trend over the past 3 years is one of improvement. Action plans are in place in each locality in order to continue to improve the performance. Whilst there has been recruitment of staff to vacancies across the services in some instances these staff members have yet to physically join the service and this is impacting on the delivery of the action plans.

Recovery Rate (KPI 7) - the Trust has failed to achieve the 50% recovery target; and the position has deteriorated further in September to the lowest level of the year to date. Action plans are in place to improve performance however the position regarding vacancies highlighted above also impacts on this position.

- Out of Locality Admissions (KPI 12) – There has been a significant improvement in performance during September resulting in the best position since April 2013 being achieved. All localities achieved the target in September.

- Appraisal (KPI 23) – There has been an improvement in performance during September which is the first improvement since June however the 3 monthly trend continues to be one of deterioration. Work continues to look at further development of the IIC in order to support the proactive management of this indicator was well attended and a one day follow up workshop is planned to take planned to take place in September.

2.2 **Appendix 2** outlines the assessment of the level of data quality of the Board Dashboard Indicators. It should be noted that the assessment for Cancelled Appointment has been reduced following some detailed work that has been undertaken to understand performance in this area. Work is ongoing between the Information Department and the services to improve the data quality around cancelled appointments.

2.3 **Appendix 3** provides further details of unexpected deaths. The breakdown by locality is now included.

3 RECOMMENDATIONS

It is recommended that the Board:

- Consider the content of this paper and raise any areas of concern/query.

Trust Dashboard Summary for TRUST

Strategic Goal 1: To provide excellent services, working with the individual users of our services and their carers to promote recovery and well being

	September 2015				April 2015 To September 2015			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	98.00%	81.45%			98.00%	81.65%		98.00%
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	98.00%	84.26%			98.00%	87.30%		98.00%
3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral.	50.00%	74.29%			50.00%	73.70%		50.00%
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	75.00%	83.59%			75.00%	81.04%		75.00%
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	95.00%	92.03%			95.00%	93.62%		95.00%
6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)	15.00%	13.08%			15.00%	13.33%		15.00%
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	50.00%	44.32%			50.00%	46.45%		50.00%
8) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post-validated	95.00%	96.30%			95.00%	97.53%		95.00%
9) Percentage CPA 7 day follow up (AMH) - post-validated	95.00%	98.86%			95.00%	97.84%		95.00%
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	98.53%			98.00%	98.53%		98.00%
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	85.00%	90.57%			85.00%	89.70%		85.00%

Trust Dashboard Summary for TRUST

Strategic Goal 2: To continuously improve the quality and value of our work

	September 2015				April 2015 To September 2015			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	7.23%			15.00%	16.00%		15.00%
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	15.00%	27.17%			15.00%	25.11%		15.00%
14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	17.00	36.00			105.00	145.00		209.00
15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	146.00	80.00			146.00	111.00		146.00
16) Percentage of appointments cancelled by the Trust	0.67%	1.07%			0.67%	1.07%		0.67%
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.00			6.00	0.00		12.00
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	75.00%	79.07%			75.00%	72.96%		75.00%

Strategic Goal 3: To recruit, develop and retain a skilled, compassionate and motivated workforce

	September 2015				April 2015 To September 2015			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	85.33%			95.00%	85.33%		95.00%
20) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	90.38%			95.00%	90.38%		95.00%
21) Percentage Sickness Absence Rate (month behind)	4.50%	4.21%			4.50%	4.51%		4.50%

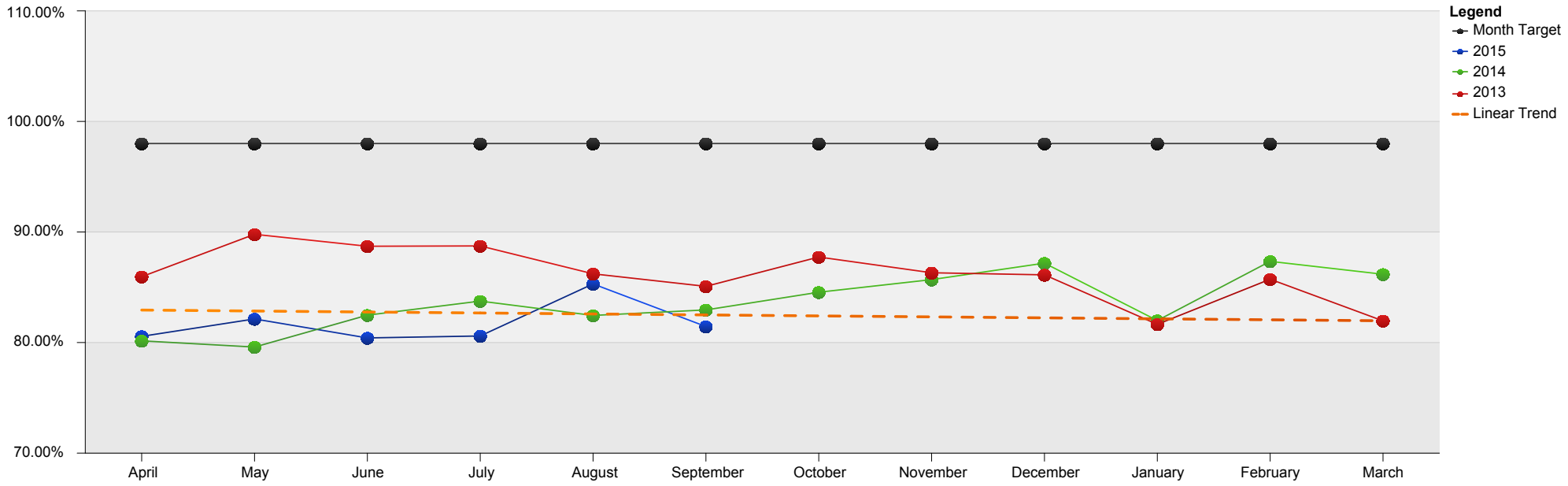
Trust Dashboard Summary for TRUST

Strategic Goal 5: To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve

	September 2015				April 2015 To September 2015			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
22) Number of reds on CQC action plans (including MHA action plans)	0.00	0.00			0.00	0.00		0.00
23) Total number of External Referrals into the Trust Services	5,747.00	6,311.00			35,061.00	36,702.00		69,931.00
24) Delivery of our financial plan (I and E)	-797,000.00	-1,098,000.00			-4,172,000.00	-4,709,000.00		-4,784,000.00

Trust Dashboard Graphs for TRUST

1) Percentage of patients seen with 4 weeks for a first appointment (external referral)



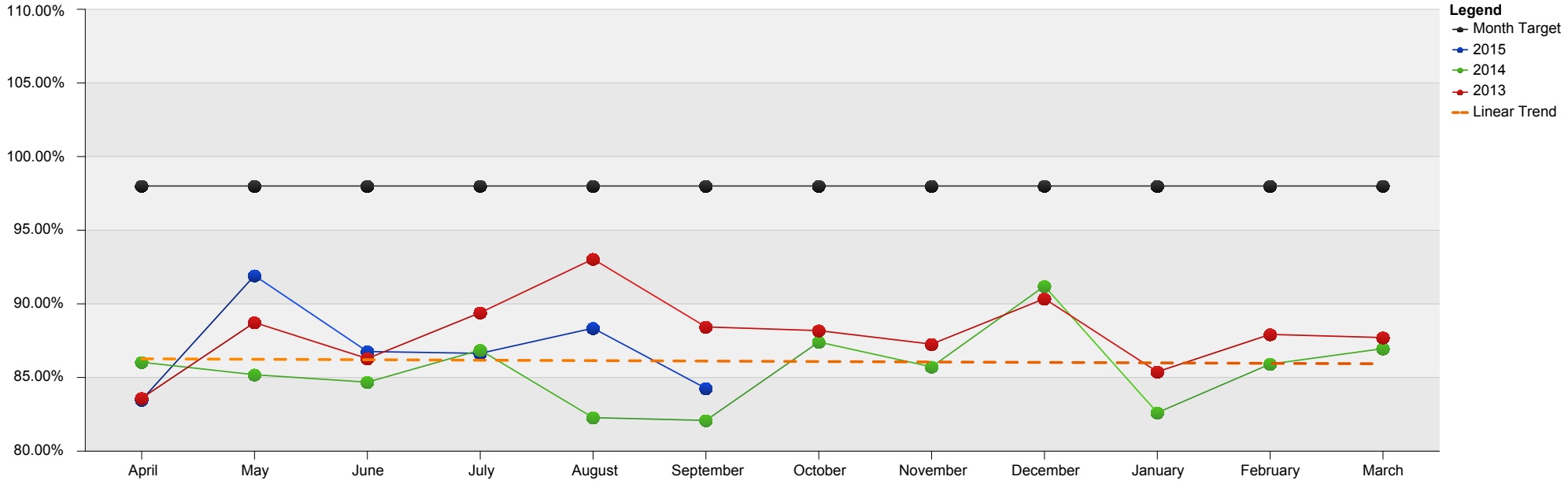
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	81.45%	81.65%	77.90%	77.37%	88.72%	88.73%	70.43%	74.27%	99.62%	99.83%

Narrative

The Trust position for September 2015 is 81.45%, which relates to 699 patients out of 3768 who had waited longer than 4 weeks for a first appointment. This is 16.55% below target, and a deterioration on August 2015 performance. The Trust position for the financial year to date is 81.65%, which is 16.35% below target.The specific areas of concern are:• Durham and Darlington CYP at 44.30% (132 patients) and AMH at 78.39% (110 patients). The average waiting time is 4.3 weeks for new referrals, with resources being aligned to achieve the target. In AMH there have been capacity issues, however recruitment is underway to fill the vacancies. • Teesside CYP at 57.71% (96 patients). Half hour screening slots are to be introduced and the reduction in length of time for assessment slots will enable the service to continue to schedule follow-up appointments. • North Yorkshire CYP at 64.29% (30 patients), MHSOP at 62.46% (110 patients) and AMH at 77.06% (106 patients). The action plan within MHSOP has not progressed as planned due to staff sickness. A request for dedicated locum support is under consideration to enable this to be progressed. Within AMH, teams have been impacted by staff sickness and vacancies.Based on past performance and September performance, there remains a significant risk that we will not achieve the annual target of 98%. The annual outturn for 2014/15 was 83.73%.

Trust Dashboard Graphs for TRUST

2) Percentage of patients seen with 4 weeks for a first appointment (internal referral)

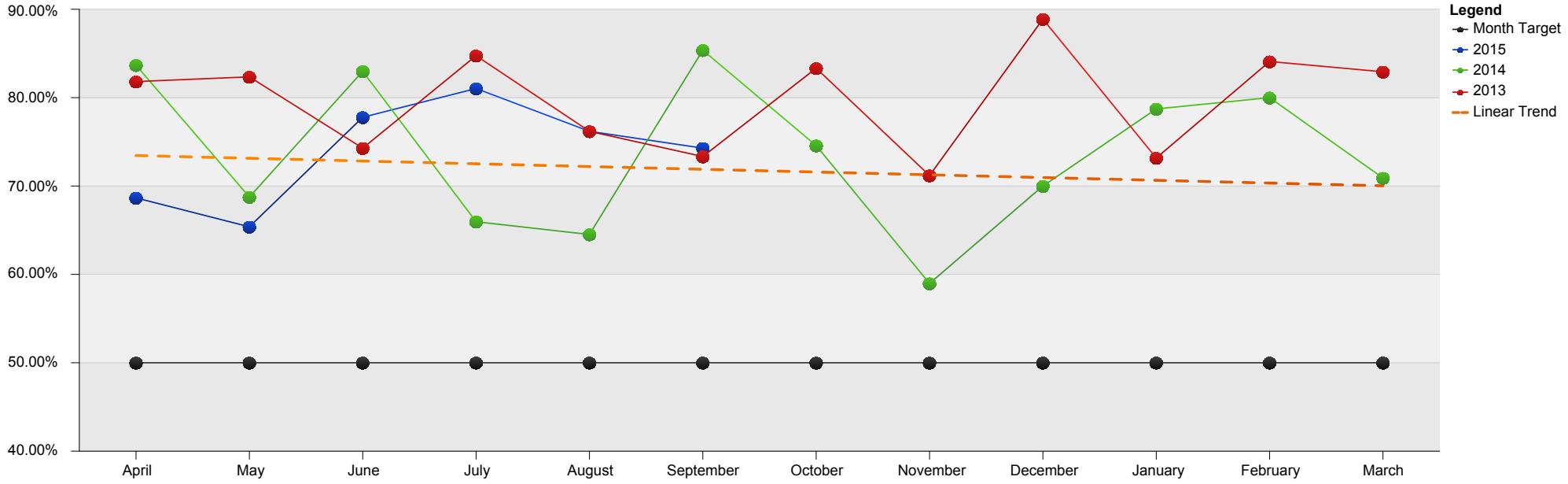


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	84.26%	87.30%	73.10%	83.28%	91.34%	91.74%	91.01%	89.57%	45.16%	50.68%

Narrative
The Trust position for September 2015 is 84.26%, which relates to 351 patients out of 2230 that were not seen within 4 weeks of an internal referral. This is 13.74% below target and a deterioration on August performance. The Trust position for the financial year to date is 87.30%, which is 10.70% below target.The specific areas of concern are:• Durham and Darlington Children & Young People's Services at 51.72% (98 patients) and Adult Mental Health Services at 78.97% (86 patients)• Teesside Children & Young People's Services at 76.87% (31 patients)• Forensic Services at 0% (16 patients), all of which are within Forensic Learning Disability autism services, which has reported an increase in referral rates that is impacting on the capacity of the team to see patients within the 4 week target.Based on past performance and September's performance there is a significant risk that we will not achieve the annual target of 98%. The annual outturn for 2014/15 was 85.79%.

Trust Dashboard Graphs for TRUST

3) Percentage of people with first episode of psychosis treated with NICE care package in two weeks

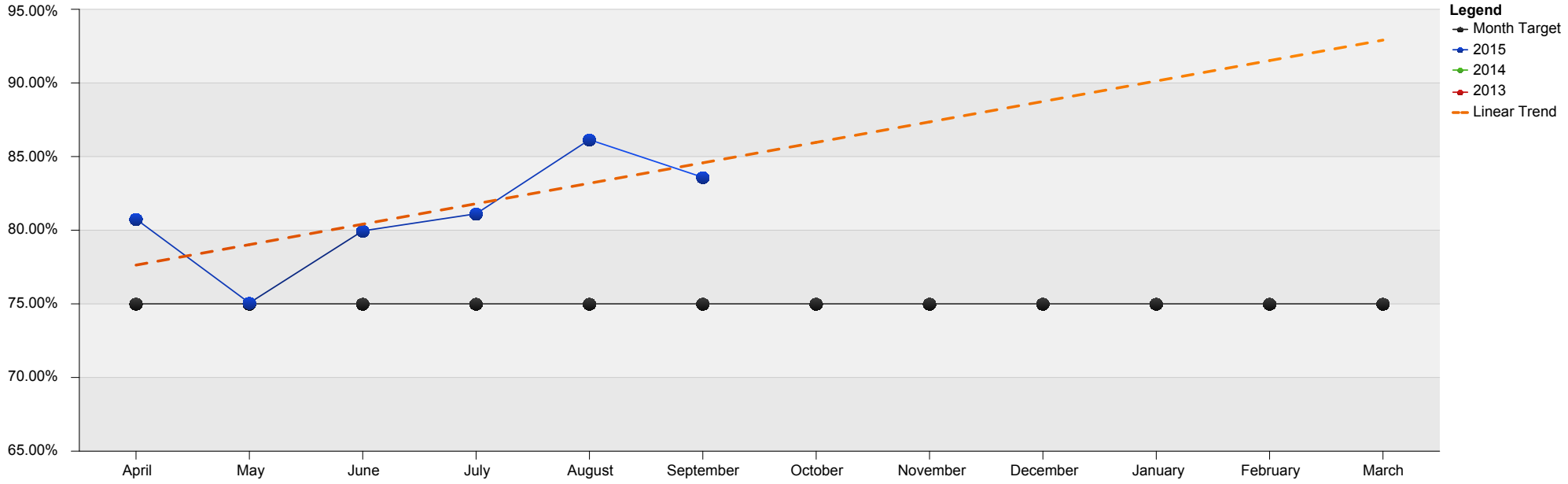


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral.	74.29%	73.70%	60.00%	61.21%	78.95%	81.02%	83.33%	81.82%	NA	NA

Narrative
The Trust position for September 2015 is 74.29%, which relates to 9 patients out of 35 that were not treated with a NICE approved care package within 2 weeks of referral. This is 24.29% above target but a deterioration on August 2015 performance. All localities are achieving target. The Trust position for the financial year to date is 73.70%, which is 23.70% above target. It should be noted that the national definition for this indicator has not yet been published.`Based on past performance and September's performance it is anticipated that we will achieve the annual target of 50%. The annual outturn for 2014/15 was 74.22%.

Trust Dashboard Graphs for TRUST

4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.



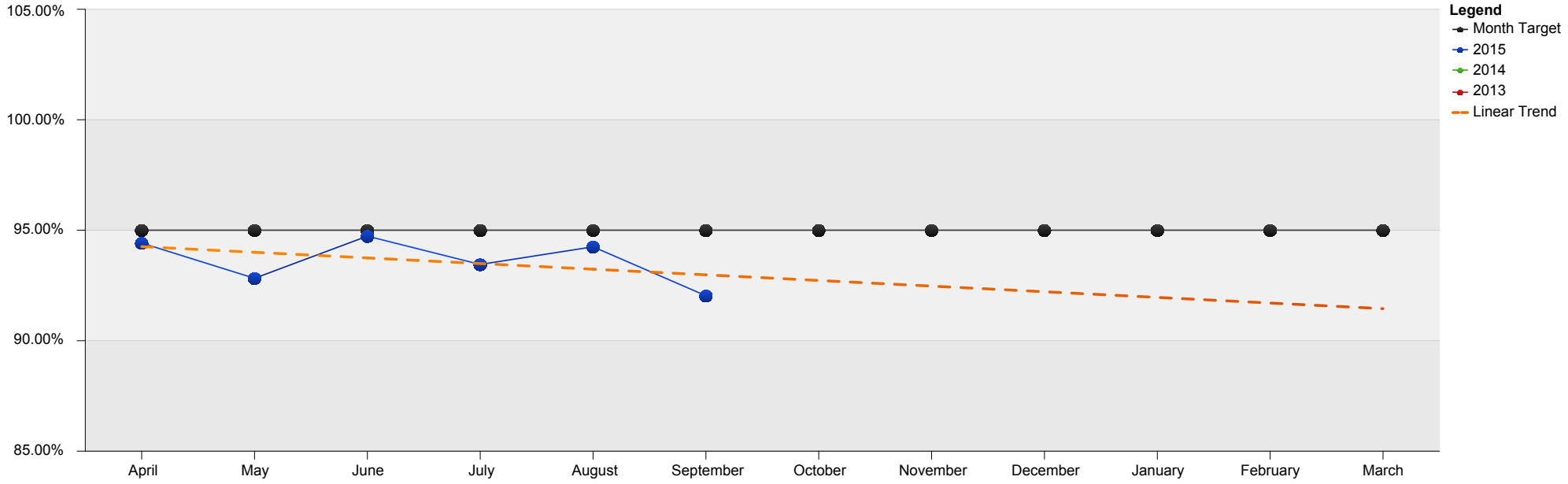
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	83.59%	81.04%	98.44%	98.43%	53.78%	59.38%	72.26%	65.84%	NA	NA

Narrative

The Trust position for September 2015 is 83.59%, which relates to 138 patients out of 841 that were not treated within 6 weeks of referral. This is 8.59% above target but a deterioration on August 2015 performance. The Trust position for the financial year to date is 81.04%, which is 6.04% above target.Durham & Darlington is above target at 98.04%. North Yorkshire is slightly below target at 72.26%. The Scarborough Hambleton & Richmondshire and Harrogate services are implementing Senior PWP roles which will release High Intensity Worker time in order to undertake therapy. It is expected this will improve the position.Teesside reports significantly below target at 53.78% and is showing a deterioration on August performance. Whilst the Service will continue to take referrals until the end of October, it is anticipated that by mid-November additional clinician time will be available for treatment, as all referrals will have been assessed. However, the service has experienced a number of staff leaving linked to the decision to cease to be a provider of IAPT services in Teesside. Based on past performance, and the improving trend in performance since May 2015, it is anticipated that we will achieve the annual target of 75%.Data only started to be collected from April 2015; therefore no comparative data for 2014/15 is available.

Trust Dashboard Graphs for TRUST

5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.



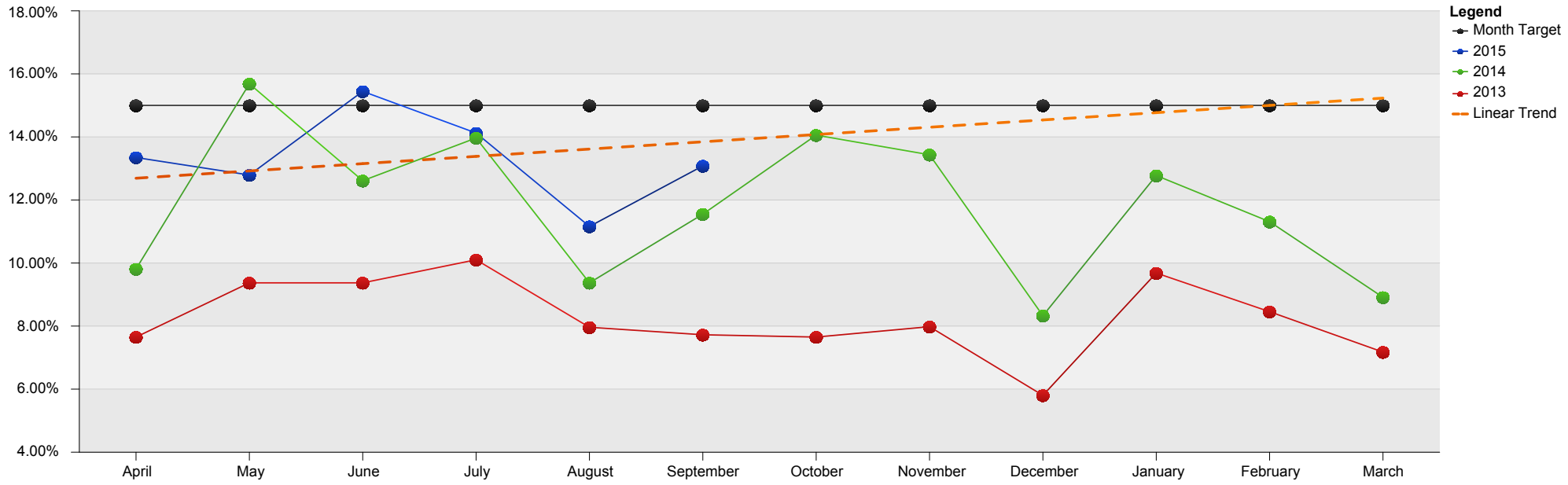
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	92.03%	93.62%	100.00%	99.84%	78.99%	79.13%	84.67%	91.85%	NA	NA

Narrative

The Trust position for September 2015 is 92.03%, which relates to 67 patients out of 841 that were not treated within 18 weeks of referral. This is 2.97% below target and a deterioration on August 2015 performance. Only Durham & Darlington are achieving target, reporting 100% for August. The Trust position for the financial year to date is 93.62%, which is 1.38% below target.North Yorkshire reports 84.67% (42 patients). The Service is currently investigating all cases to understand why the delays have occurred.Teesside reports 78.99% (25 patients not treated within 18 weeks). The service monitors patients waiting for treatment on a weekly basis. Patients who are waiting to enter treatment have been advised of the likely date of start of treatment and offered an alternative provider. Whilst the Service will continue to take referrals until the end of October, it is anticipated that by mid-November additional clinician time will be available for treatment, as all referrals will have been assessed. However, the service has experienced a number of staff leaving linked to the decision to cease to be a provider of IAPT services in Teesside. Based on past performance and September's performance there is a risk that we will not achieve the annual target of 98%. Data only started to be collected from April 2015; therefore no comparative data for 2014/15 is available.

Trust Dashboard Graphs for TRUST

6) Access to Psychological Therapies - Adult IAPT

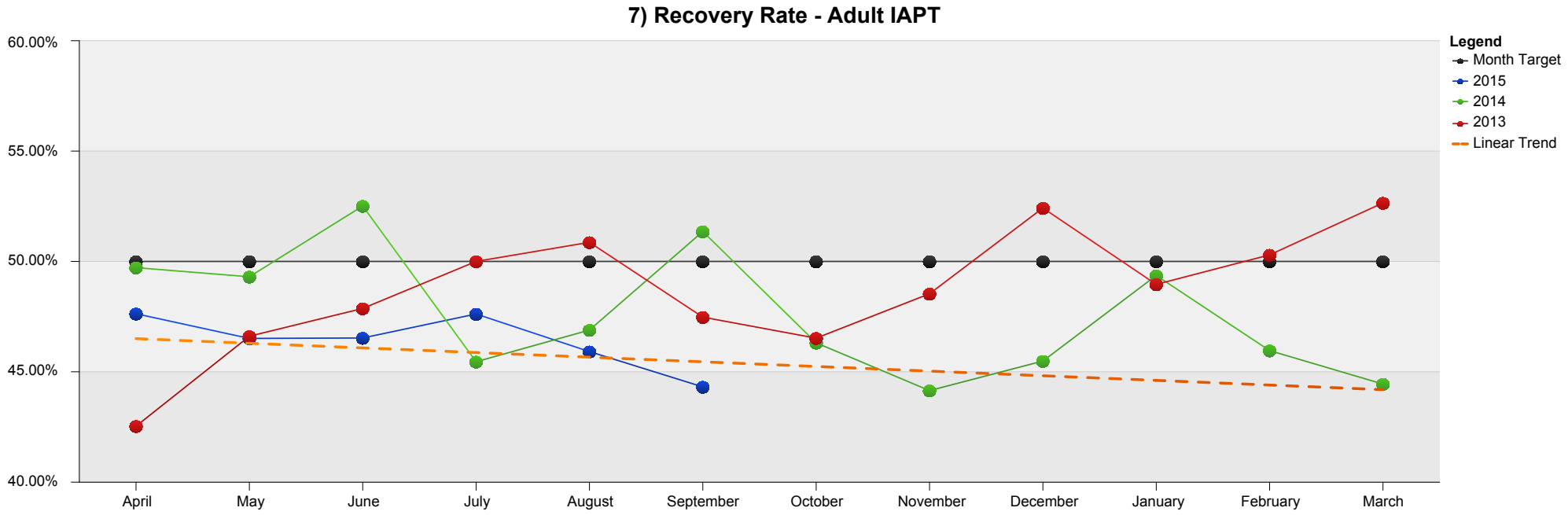


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)	13.08%	13.33%	12.83%	12.73%	NA	NA	13.47%	14.24%	NA	NA

Narrative

The Trust position for September 2015 is 13.08% which equates to 1178 people entering treatment from 9005 of the general population. This is 1.92% below the target of 15% but is an improvement on August 2015 performance and higher than September 2013 and 2014. The Trust position for the financial year to date is 13.33%, which is 1.67% below target. North Durham CCG (14.16%), DDES CCG (10.99%) and Darlington (14.71%) are below target. There remains a high number of referrals for step 2a treatment and referrals are being automatically allocated to manage demand. In addition, the Therapy Support Workers are now in post and it is anticipated they will start to pick up cases by the end of October.Scarborough & Ryedale CCG (14.31%), Hambleton, Richmondshire & Whitby CCG (14.59%), Harrogate & Rural CCG (12.49%) and Vale of York CCG (8.32%) are below target. An action plan is in place to address this and recruitment processes within the services continue. Harrogate have also contacted all GP practices within the area with a view to raising awareness of the positive impact that referral to IAPT can achieve. Based on past performance and September's performance, there is a risk that we will not achieve the annual target of 15%, unless further action is taken.The annual outturn for 2014/15 was 11.82%.

Trust Dashboard Graphs for TRUST

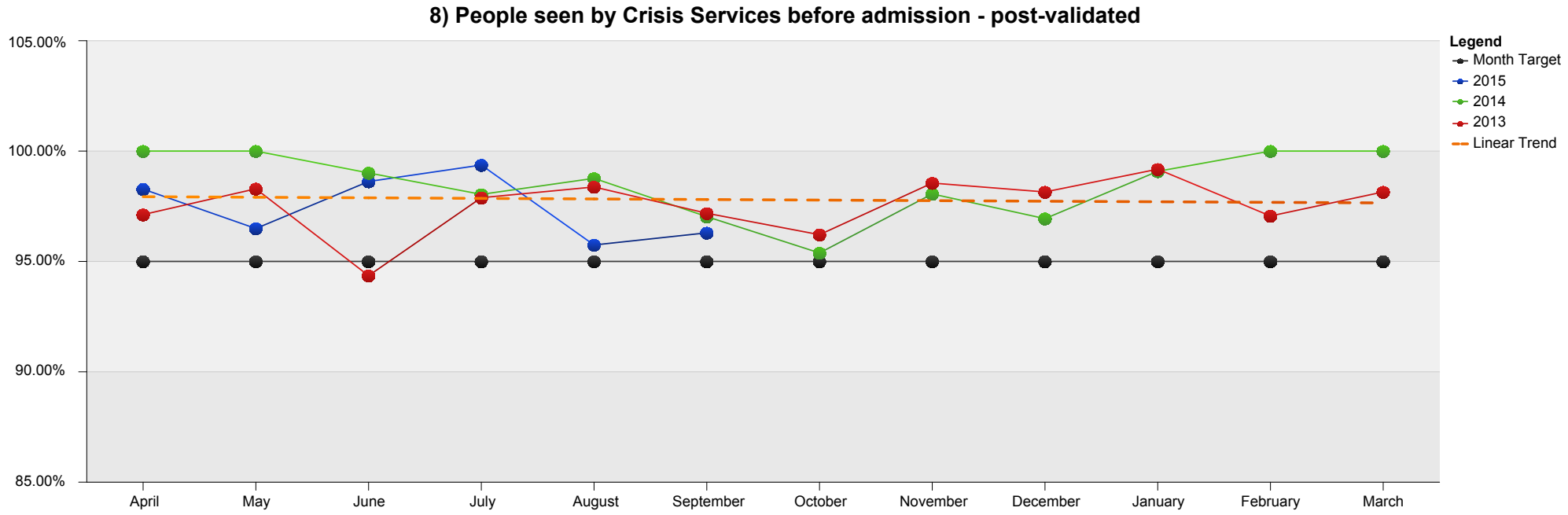


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	44.32%	46.45%	44.50%	44.89%	40.17%	45.96%	45.97%	49.21%	NA	NA

Narrative

The Trust position for September 2015 is 44.32%, with 431 people out of 774 not achieving recovery. This is 5.68% below the target of 50% and a slight deterioration on August performance. All localities are under target. The Trust position for the financial year to date is 46.45%, which is 3.55% below target.Darlington CCG (40.00%) and North Durham CCG (45.09%) have reported a deterioration, whereas DDES CCG (45.96%) has reported an improvement. The service are currently addressing issues in terms of patients who drop out of treatment and patient engagement during supervision sessions. Hartlepool & Stockton CCG (43.75%) has reported an improvement in performance, whereas South Tees CCG (37.68%) have reported a deterioration. The action plan is progressing, with most actions now completed.Scarborough & Ryedale CCG (40.91%) and Hambleton, Richmondshire & Whitby CCG (48.91%) have reported improvements, whereas Harrogate & Rural CCG (45.63%) and Vale of York CCG (44.44%) have reported deteriorations. Recruitment continues and in Scarborough, analysis on the severity of illnesses at referral is to be shared with commissioners to identify further courses of action.September reports the lowest position to date this year; based on this and past performance, there is a risk that we will not achieve the annual target of 50%.The annual outturn for 2014/15 was 47.63%.

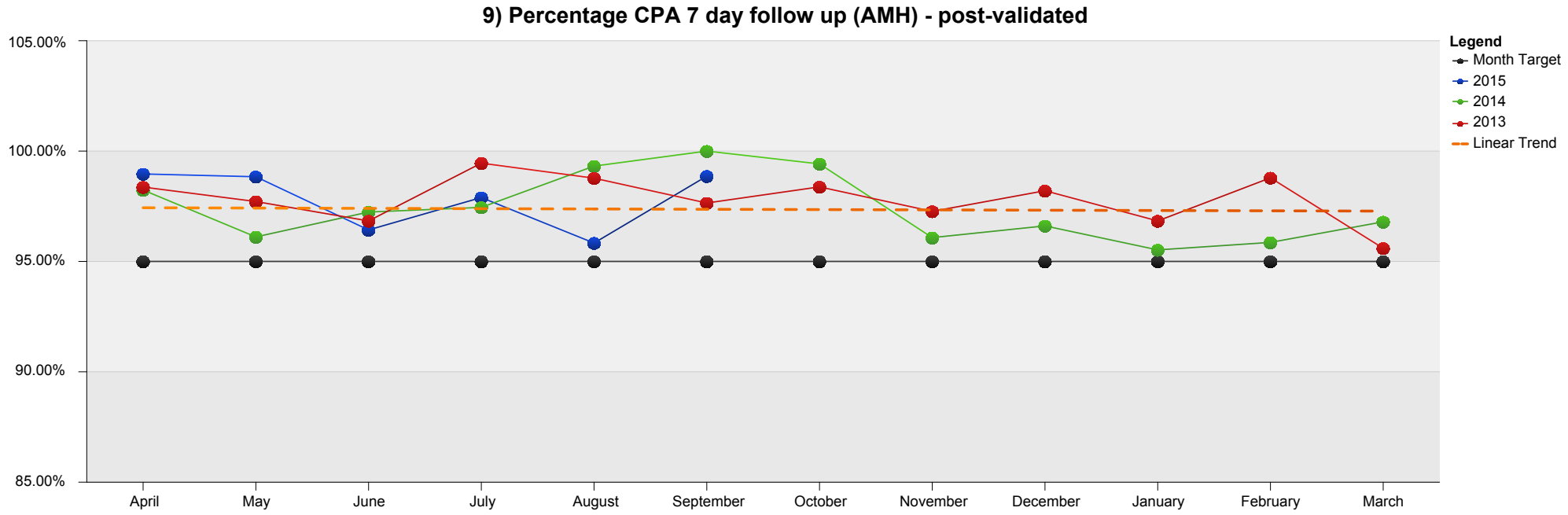
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post-validated	96.30%	97.53%	94.44%	96.98%	96.30%	97.57%	97.78%	98.07%	NA	NA

Narrative
The Trust post validated position for September 2015 is 96.30%, which relates to 5 patients out of 135 that were not seen by a Crisis Home Treatment Team prior to admission. This is 1.30% above the target and an improvement on August performance. The Trust post validated position for the financial year to date is 97.53%, which is 2.40% above target.The Corporate Performance Team continues to raise awareness of the crisis gatekeeping requirements with wards, crisis teams and Heads of Service.Based on past performance and performance during September it is anticipated that we will achieve the annual target of 95%.The annual outturn for 2014/15 was 98.42%.

Trust Dashboard Graphs for TRUST

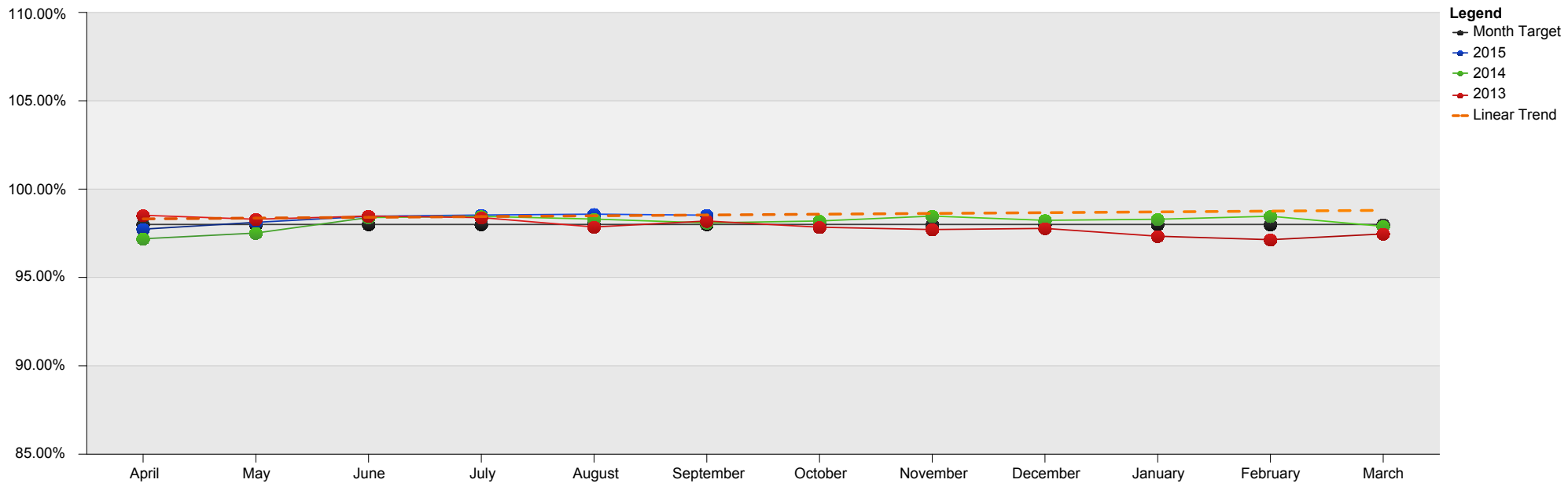


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) Percentage CPA 7 day follow up (AMH) - post-validated	98.86%	97.84%	97.37%	98.33%	100.00%	98.32%	100.00%	96.12%	NA	NA

Narrative
The Trust post validated position for September 2015 is 98.86% which relates to 2 patients out of 176 that were not followed up within 7 days of discharge. This is 3.86% above the target and a significant improvement on August performance. The Trust post validated position for the financial year to date is 97.84%, which is 2.84% above target.Based on past performance and September's performance, it is anticipated that we will achieve the annual target of 95%.The annual outturn for 2014/15 was 97.42%.

Trust Dashboard Graphs for TRUST

10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)

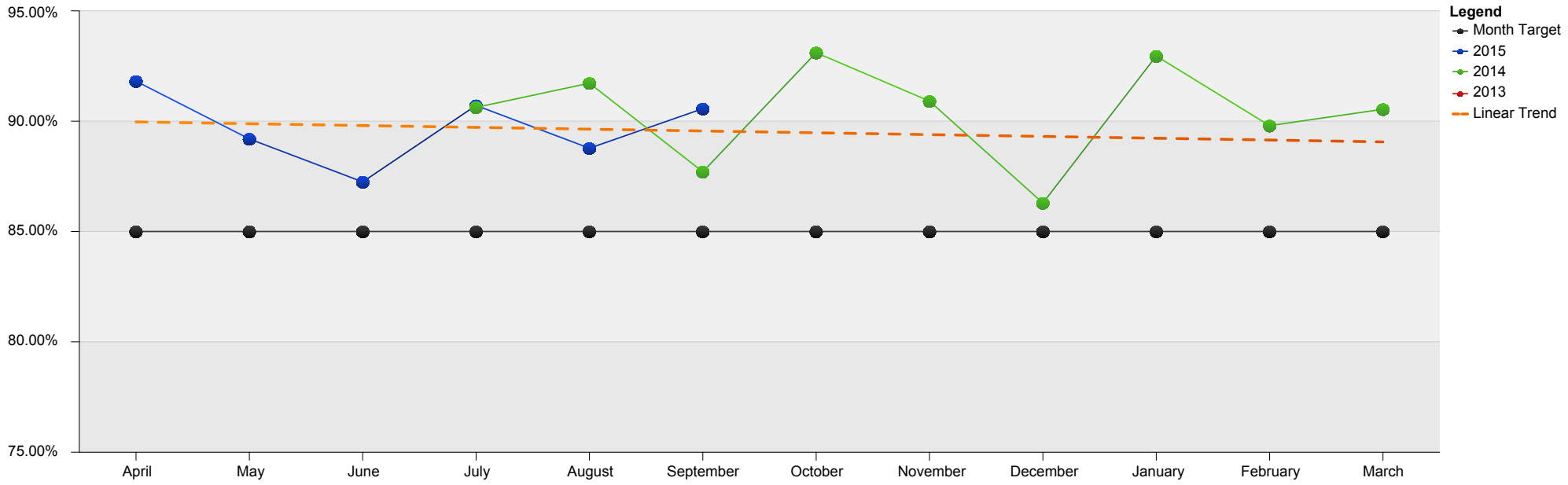


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.53%	98.53%	98.02%	98.02%	99.61%	99.61%	98.05%	98.05%		

Narrative
The Trust position for September 2015 is 98.53% which relates to 61 patients out of 4138 that had not had a formal review documented within 12 months. This is 3.53% above the Monitor target of 95%, 0.53% above the Trust target of 98% and a very slight improvement on August performance. All localities are achieving target for this first time this year.Since May performance has consistently been above target and it is expected that we will achieve the annual target of 98%.The annual outturn for 2014/15 was 97.90%.

Trust Dashboard Graphs for TRUST

11) Community patients involved in the development of their care plan (month behind)

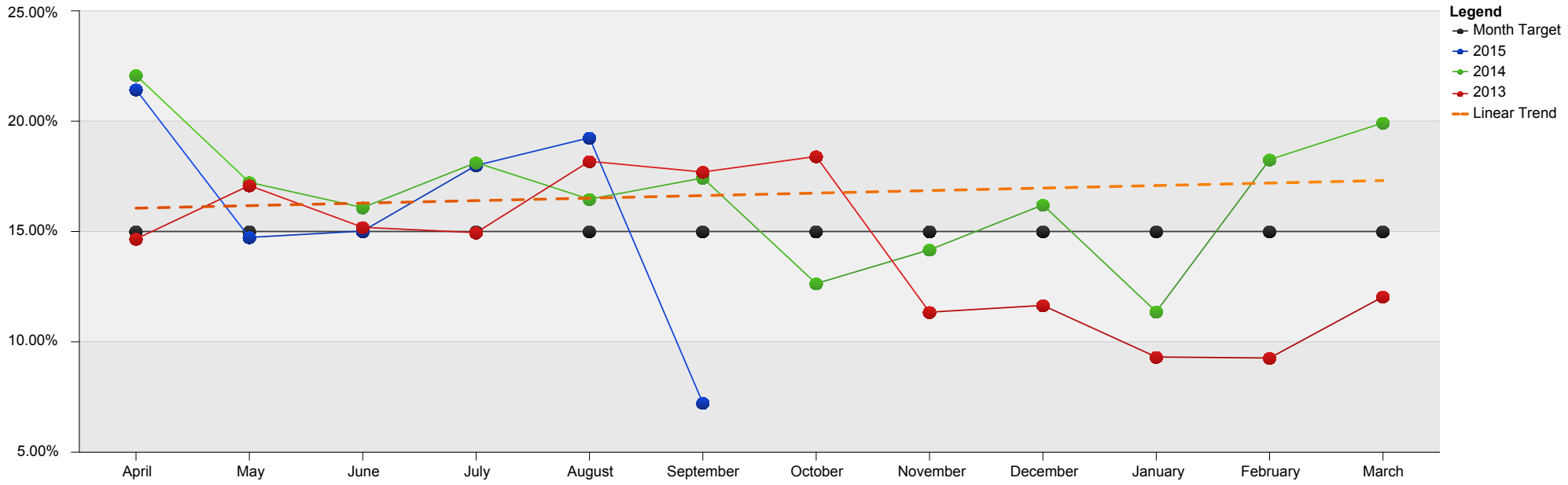


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	90.57%	89.70%	91.72%	89.82%	90.00%	90.08%	89.23%	88.93%	100.00%	95.00%

Narrative
The position reported in September 2015 relates to August performance. The Trust position for August 2015 is 90.57%, which relates to 50 patients out of 530 that state they have not been involved in the development of their care plan. This is 5.57% above the target of 85% and an improvement on the performance reported for July. The Trust position for the financial year to date is 89.70%, which is 4.70% above target.Based on past performance and August's performance, it is anticipated that we will achieve the annual target of 85%.As this indicator is reported a month behind, it must be noted the financial year will be calculated from March of the previous year to February within the current year (inclusive).The annual outturn for 2014/15 was 90.58%

Trust Dashboard Graphs for TRUST

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



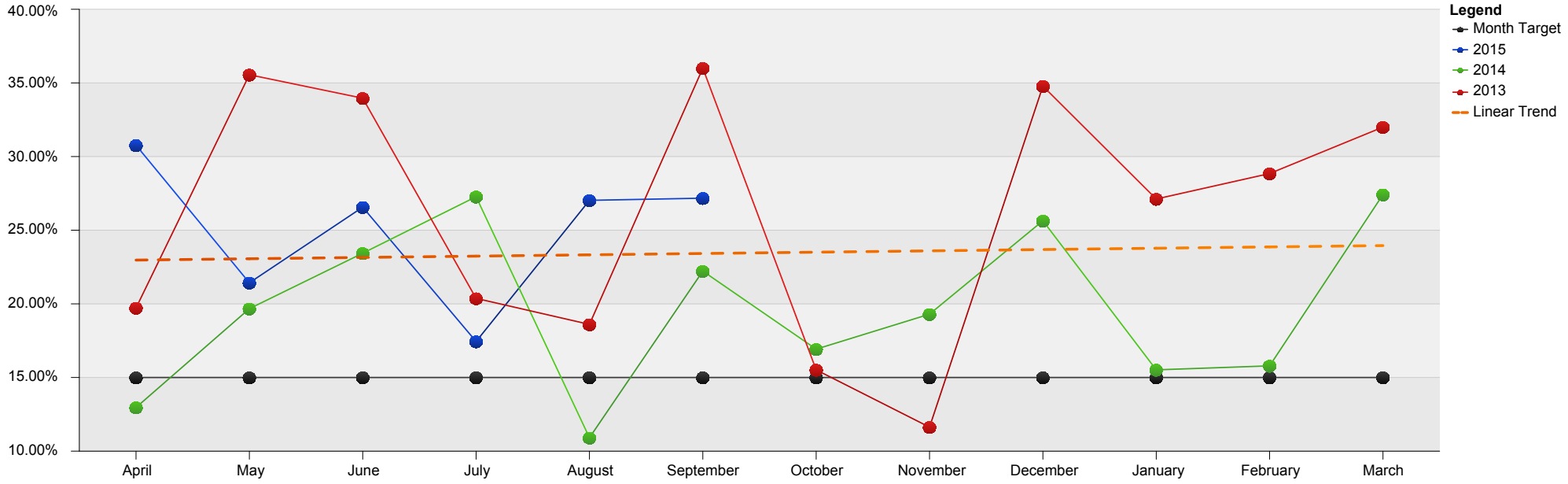
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	7.23%	16.00%	5.43%	17.67%	7.95%	7.24%	8.70%	25.46%	NA	NA

Narrative

The Trust position for September 2015 is 7.23%, which relates to 18 admissions out of 249 that were admitted to out of locality assessment and treatment wards. This is 7.77% below the target of 15% and an improvement on the position reported in August. All localities are below target The Trust position for the financial year to date is 16.00%, which is 1.00% above target.Of the 18 patients admitted to an 'out of locality' bed (AMH 10, MHSOP 8), all were due to no beds being available at their local hospital.The localities continue to investigate ways in which they can improve OOL admissionsThis is the best position we have reported since April 2013 and should this improvement continue it is possible we will achieve the annual target of 15.00%.

Trust Dashboard Graphs for TRUST

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



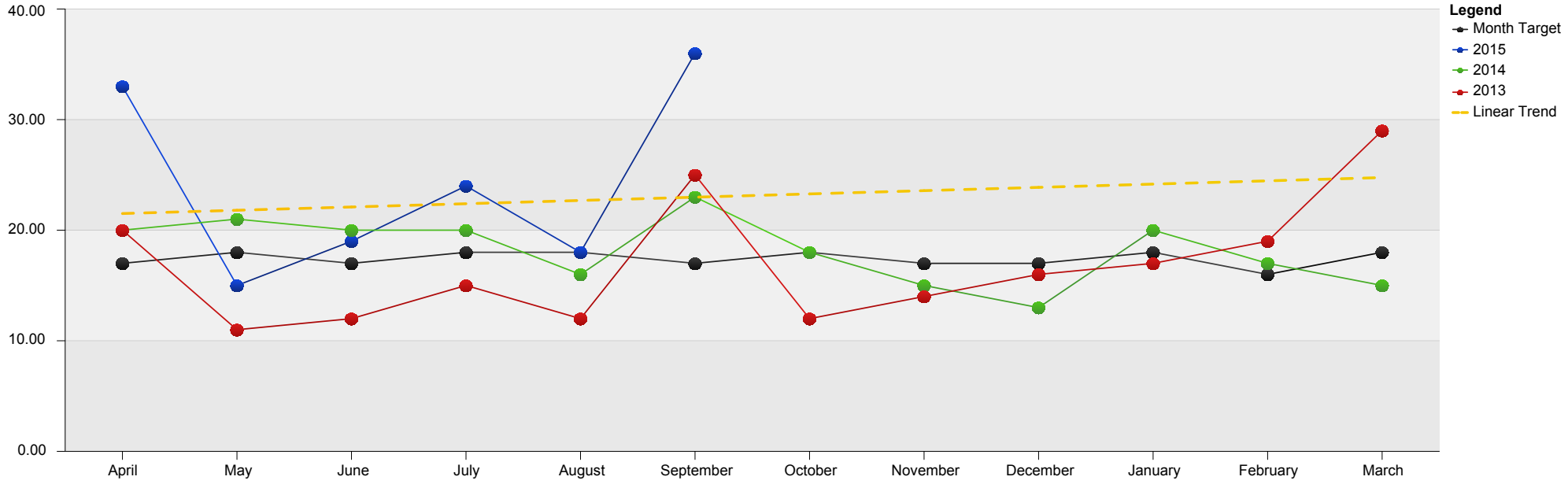
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	27.17%	25.11%	12.00%	23.19%	36.11%	22.62%	30.00%	30.00%	NA	NA

Narrative

The Trust position for September 2015 is 27.17%, which relates to 25 patients out of 92 that were readmitted within 30 days. This is 12.17% above the target of 15% and a slight deterioration on the position reported in August. The Trust position for the financial year to date is 25.11%, which is 10.11% above target.23 of the 25 readmissions were within AMH Services:• 3 (13%) were within Durham & Darlington • 12 (52%) were within Teesside. The Modern Matrons review the reasons for all patients re-admitted within 30 days and they were all clinically valid. • 8 (35%) were within North Yorkshire No particular patterns or trends in terms of wards or community teams can be identified.2 admissions were for MHSOP:• 1 (50%) was within North Yorkshire• 1 (50%) was within TeessideBased on past performance and an increasing trend since July, there remains a risk that we will not achieve the annual target of 15%, unless further action is taken.The annual outturn for 2014/15 was 19.89%.

Trust Dashboard Graphs for TRUST

14) Number of instances of patients who have 3 or more admissions in a year (AMH and MHSOP)

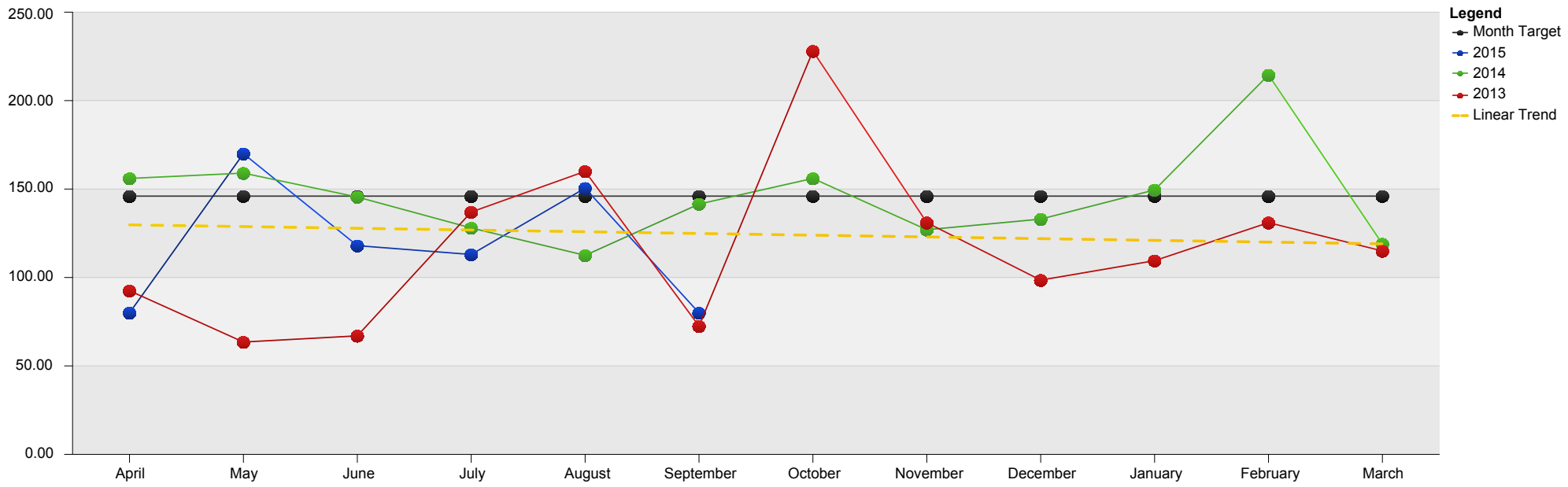


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	36.00	145.00	10.00	50.00	15.00	43.00	11.00	51.00	NA	NA

Narrative
The Trust position for September 2015 is 36, which is 19 above the target of 17 and a significant deterioration on the position reported in August. The Trust position for the financial year to date is 145, which is 40 above target.Of the 36 readmissions:• 10 (27.28%) were Durham & Darlington AMH patients.• 15 (41.67%) were Teesside patients - AMH 14, MHSOP 1.• 11 (30.56%) were North Yorkshire Adult Mental Health patients.September has reported the highest number of instances since April; however to date, performance this year has mirrored the trend observed in previous years and should that continue a downward trajectory could be anticipated for the remaining six months. Nevertheless, there remains a risk that we will not achieve the annual target of 209.The annual outturn for 2014/15 was 219.

Trust Dashboard Graphs for TRUST

15) Median number of days between admissions (AMH & MHSOP) - Monthly

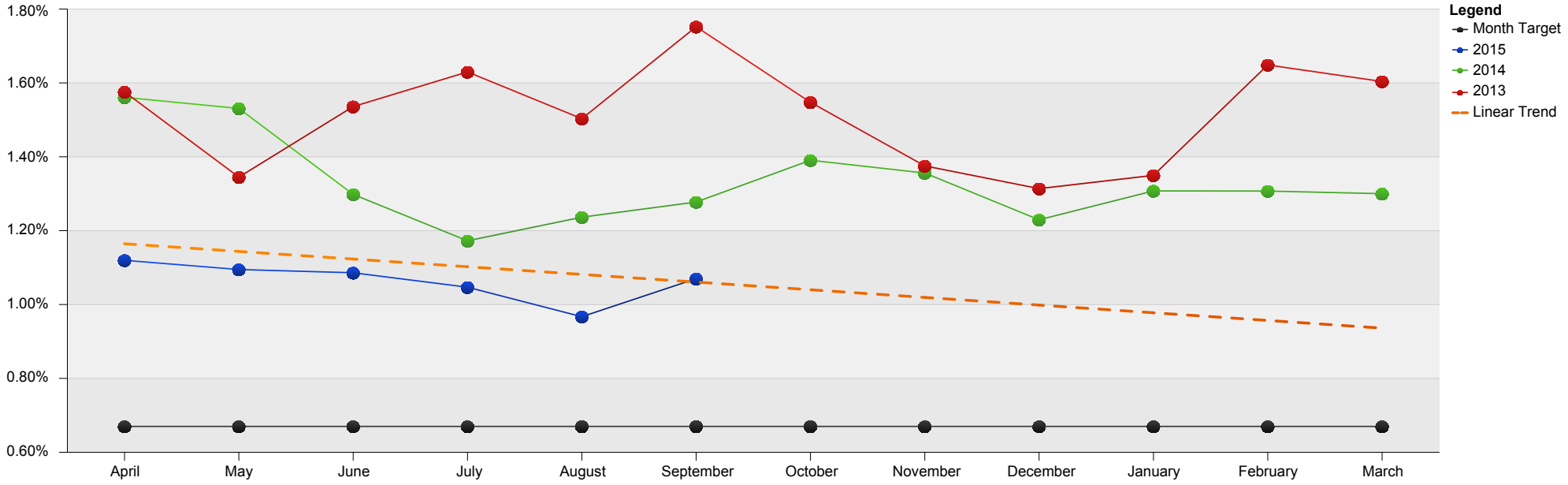


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	80.00	111.00	136.00	129.00	106.00	139.00	73.00	80.00	NA	NA

Narrative
The Trust position for September 2015 is 80, which is 66 below the target of 146 and a significant deterioration on August performance. The Trust position for the financial year to date is 111, which is 35 below target.Based on past performance and September's performance, there is a risk that we will not achieve the annual target of 146.The annual outturn for 2014/15 was 139.

Trust Dashboard Graphs for TRUST

16) Percentage of appointments cancelled by the Trust

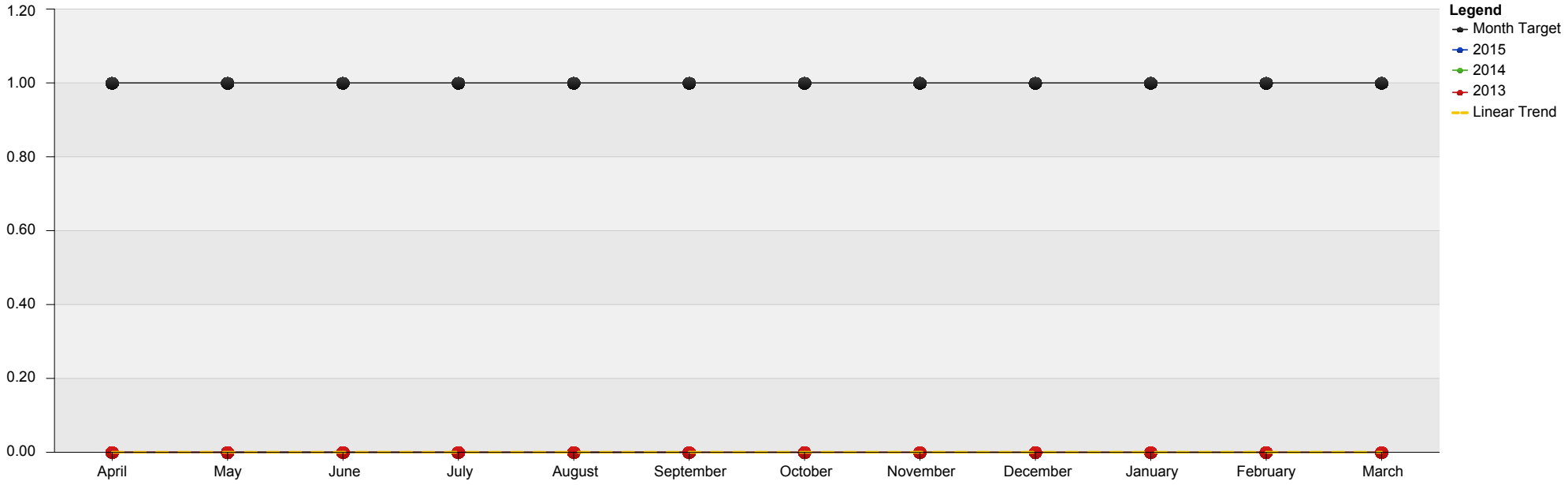


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of appointments cancelled by the Trust	1.07%	1.07%	1.07%	1.08%	0.91%	1.01%	1.49%	1.31%	0.10%	0.06%

Narrative
The Trust position for September 2015 is 1.07%, which relates to 829 appointments out of 77,475 that have been cancelled. This is 0.40% above the target of 0.67% and a deterioration compared to August performance. The Trust position for the financial year to date is 1.07%, which is 0.39% above target.All localities are failing to achieve target; however, it has been identified that some of these cancellations may be due to how clinics are managed and investigations into this continue. This work is being coordinated by the Data Quality Working Group who report progress to the Data Quality Group on a regular basis.Based on past performance and September performance, there remains a risk that we will not achieve the annual target of 0.67%, unless further action is taken.The annual outturn for 2014/15 was 1.33%.

Trust Dashboard Graphs for TRUST

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

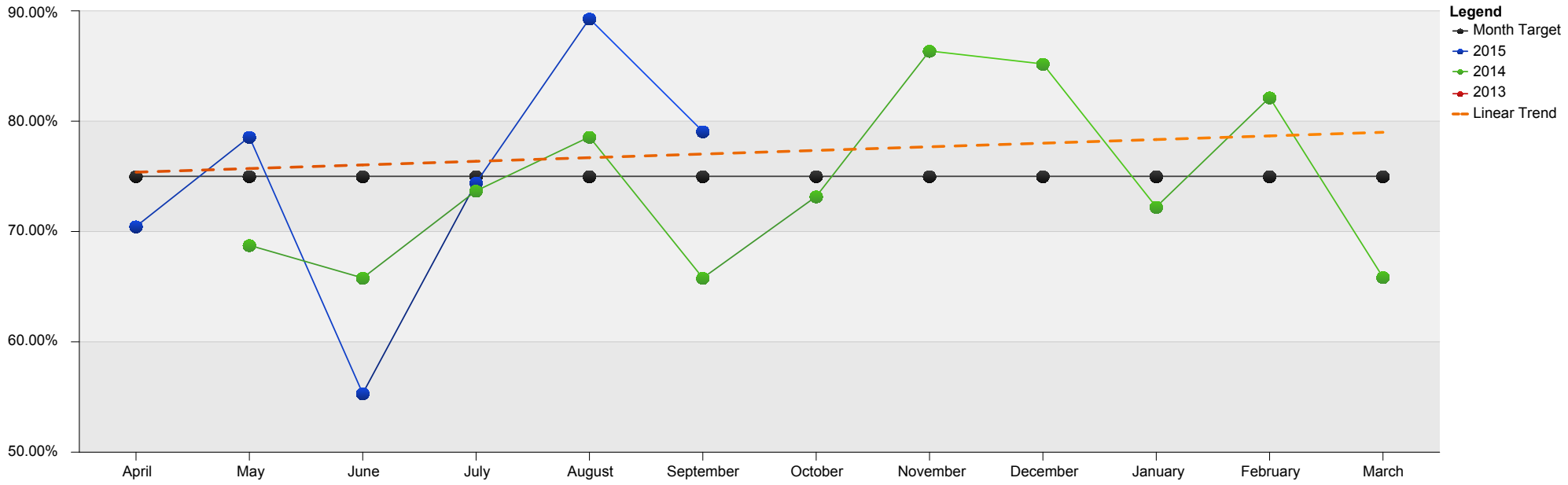


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Narrative
It is not currently possible to report this indicator due to late changes in the data that IIC are unable to action within the timeframe required

Trust Dashboard Graphs for TRUST

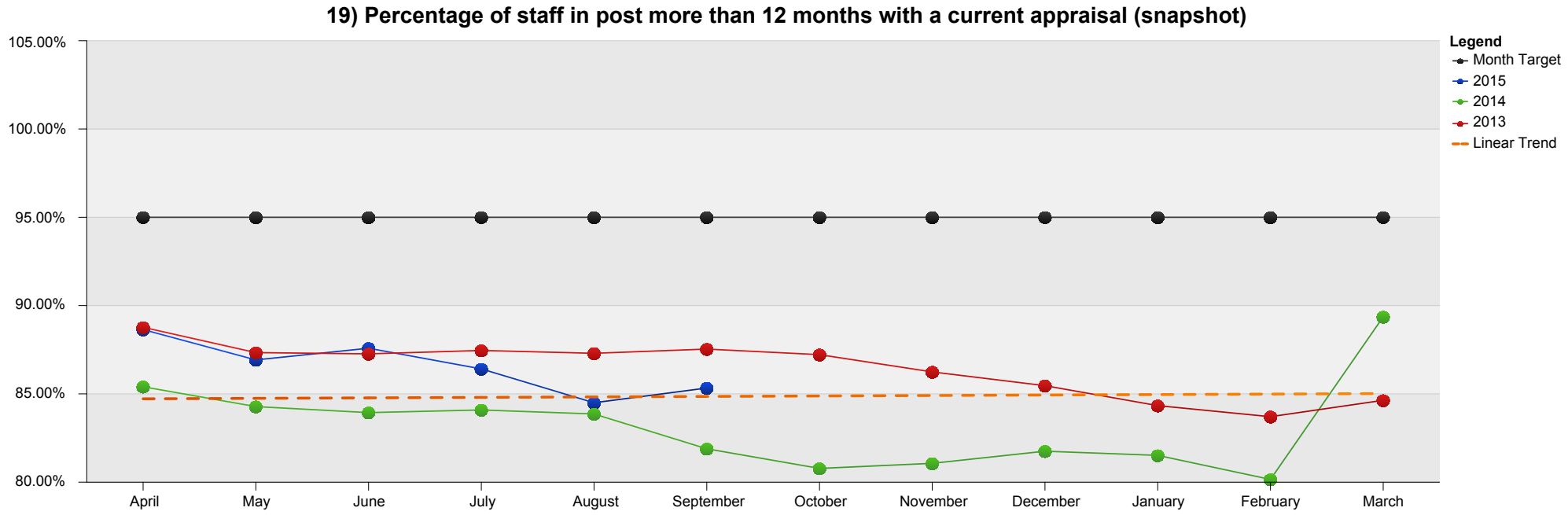
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	79.07%	72.96%	81.82%	84.29%	100.00%	88.52%	77.78%	72.09%	58.33%	35.29%

Narrative
The Trust position reported in September relates to August performance. The Trust position for August 2015 is 79.07% with 9 wards out of 43 wards surveyed in August not scoring higher than 80%. This is 4.07% above the target of 75.00% but a deterioration on July's position. Only Forensics Services (58.33%) is failing to achieve target, accounting for 5 wards. The Trust position for the financial year to date is 72.96%, which is 2.04% below target.The position within Forensics is largely attributable to the low numbers of surveys that are being returned by patients. Discussions continue within the service as to how this can be improved, as given the inherent nature of forensic patients being detained it is less likely that that they will be positive about the experience on the ward. Performance at Trust level has reported an improving trend since June (May's data) and should this continue there is a possibility that we will achieve the annual target of 75%.As this indicator is reported a month behind, it must be noted the financial year will be calculated from March of the previous year to February within the current year (inclusive).The annual outturn for 2014/15 was 73.17%.

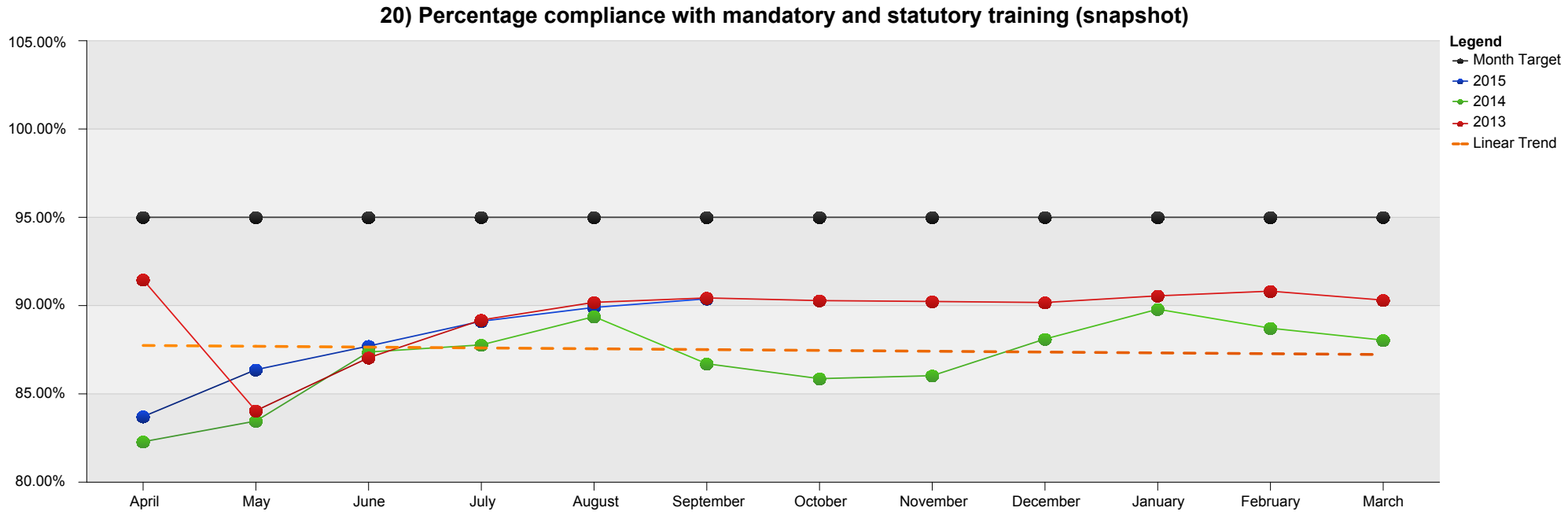
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	85.33%	85.33%	82.18%	82.18%	86.06%	86.06%	85.66%	85.66%	89.31%	89.31%

Narrative
The Trust position for September 2015 is 85.33% which relates to 760 members of staff out of 5181 that do not have a current appraisal. This is 9.67% below the target of 95% but a slight improvement on August's position. 24 staff had their pay progression withheld at the end of September due to non-compliance of mandatory training and/or appraisal, this is slightly higher than the figure of 20 reported in August. 23 staff are showing as non-compliant at the end of October. Managers are able to access compliance reports through the IIC to monitor performance against the target of 95%. Monitoring of compliance against the target is discussed at the Performance Improvement Group where Directors of Operations provide details of actions being taken to improve compliance. A workshop was held in September to identify how the IIC can be developed further to present HR related information. A meeting has been held with the Head of Corporate Performance to identify KPIs for development and one is arranged with the Financial Controller to view a proposed format; however further progress has been delayed due to capacity issues in the HR Directorate. Based on the deteriorating trend and September's performance, there is a significant risk that we will not achieve the annual target of 95%, unless further action is taken.The annual outturn for 2014/15 was 85.41%.

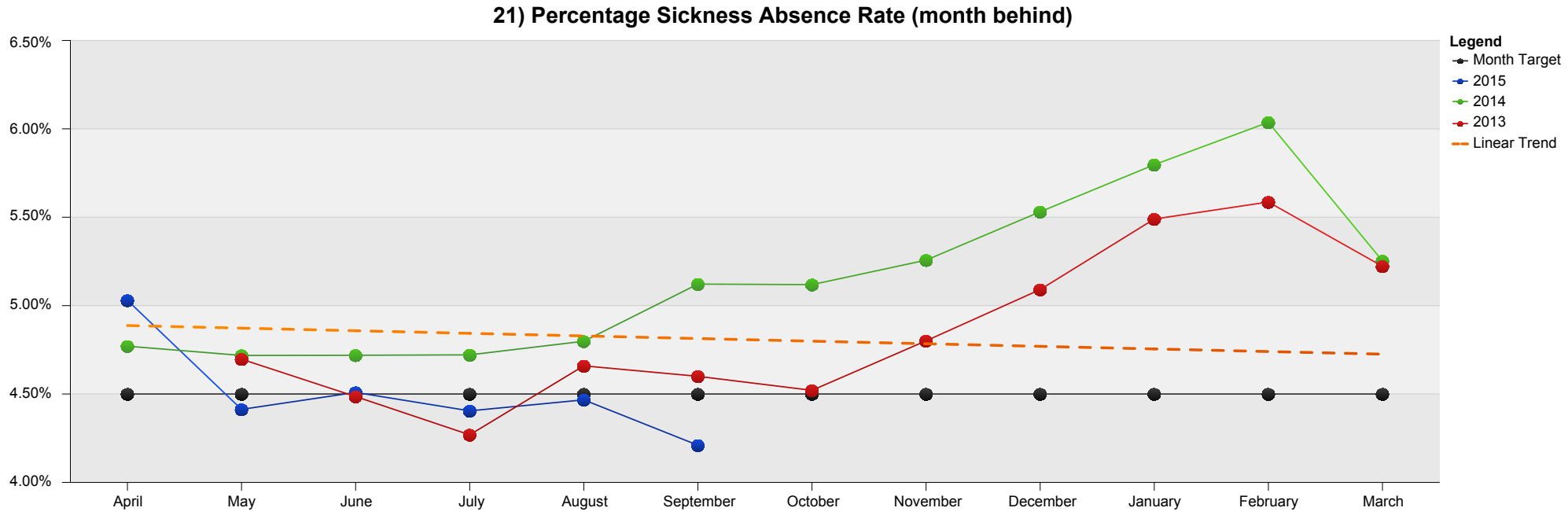
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) Percentage compliance with mandatory and statutory training (snapshot)	90.38%	90.38%	88.90%	88.90%	91.45%	91.45%	86.46%	86.46%	91.59%	91.59%

Narrative
The position for September 2015 is 90.38%. This is 4.62% below the target of 95% but a slight improvement on August 2015 performance.Regular monthly reports are produced for Heads of Service and line managers to monitor performance against the target of 95%. The workshop held in September to identify how the IIC can be developed further to present HR related information also focused on the mandatory training reports. Further work is to be undertaken.Whilst the improving trend since April 2015 continues, there is still a risk that we will not achieve the annual target of 95%, unless further action is taken.The annual outturn for 2014/15 was 82.29%.

Trust Dashboard Graphs for TRUST



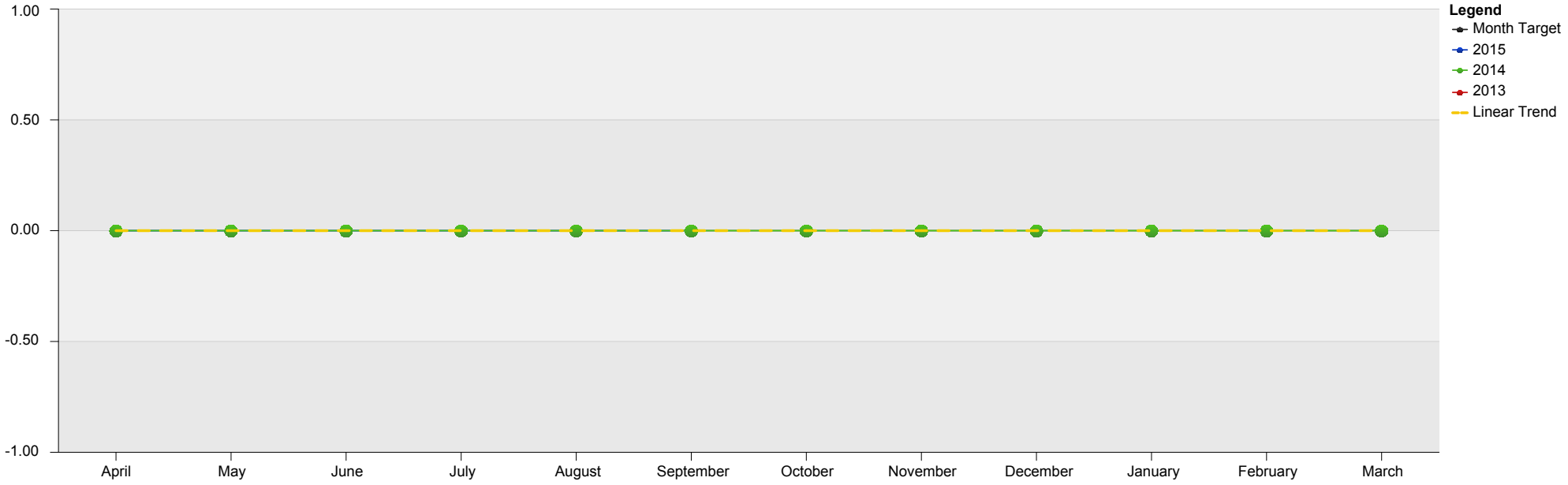
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Percentage Sickness Absence Rate (month behind)	4.21%	4.51%	4.21%	4.42%	4.45%	4.78%	3.84%	4.33%	5.51%	6.14%

Narrative

The Trust position reported in September relates to the August sickness level. The Trust position reported in August 2015 is 4.21%, which is 0.29% below the Trust target of 4.50% and an improvement on the position reported for July. The Trust position for the financial year to date is 4.51%.Based on past performance where sickness increases in the latter half of the year, there is a risk that we will not achieve the annual target of 4.50%; however, a decreasing trend has been reported since February with September 2015 reporting the best position since April 2013. Should this improvement continue, the target could be achieved.As this indicator is reported a month behind, it must be noted the financial year will be calculated from March of the previous year to February within the current year (inclusive).The annual outturn for 2014/15 was 5.12%.

Trust Dashboard Graphs for TRUST

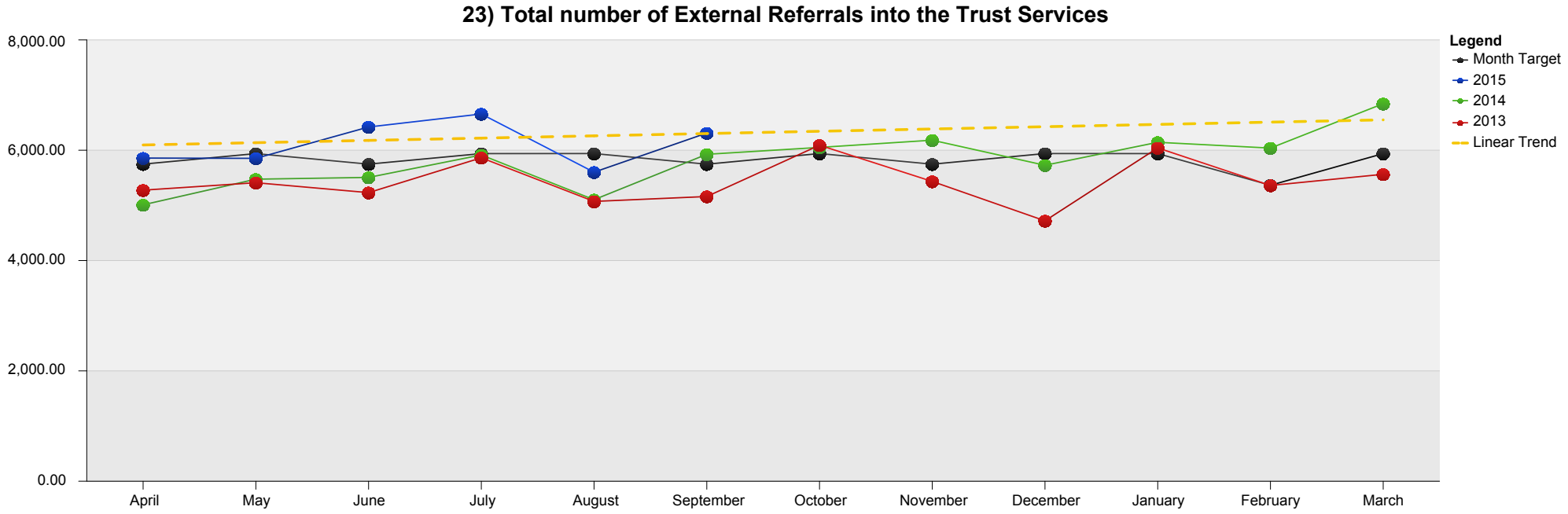
22) Number of reds on CQC action plans (including MHA action plans)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
22) Number of reds on CQC action plans (including MHA action plans)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Narrative
The Trust position for September 2015 is zero, which is consistent with 2014/15 reporting.Based on past performance and September's performance, it is anticipated that we will achieve the annual target.The annual outturn for 2014/15 was 0.

Trust Dashboard Graphs for TRUST

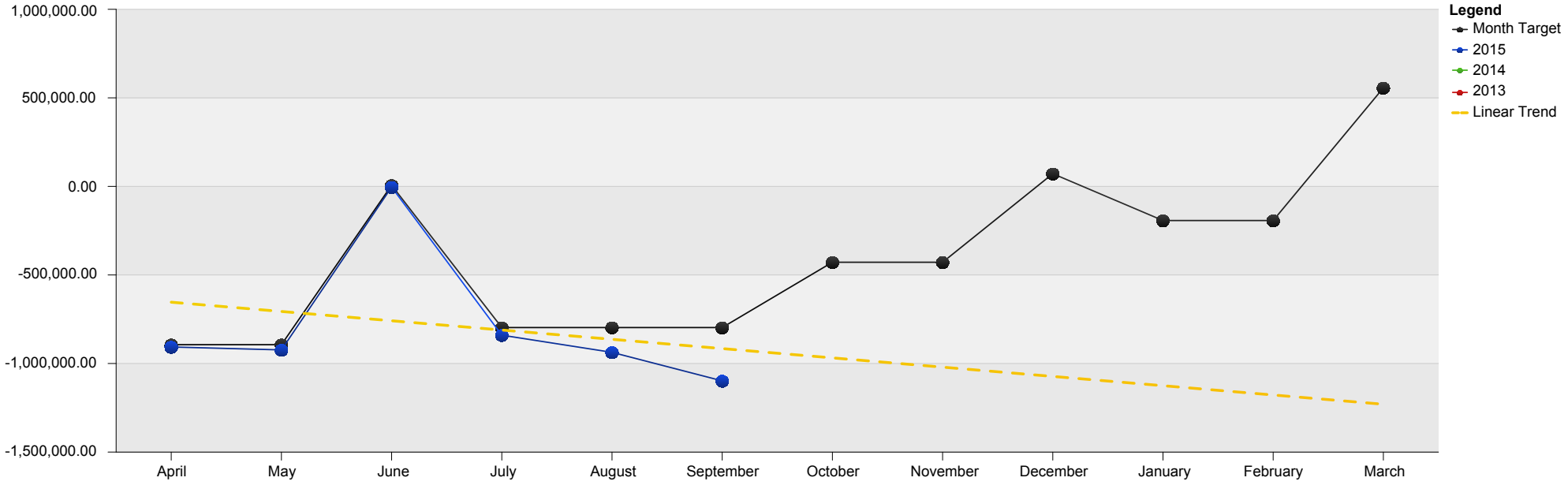


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
23) Total number of External Referrals into the Trust Services	6,311.00	36,702.00	1,837.00	11,234.00	2,043.00	12,024.00	1,785.00	10,856.00	607.00	2,544.00

Narrative
The Trust position for September 2015 is 6311, which is 564 above the Trust target of 5,747 and an increase on the number received in August. This is also higher than the numbers reported in September 2013 and 2014. The Trust position for the financial year to date is 36,702, which is 1641 above target. This slight increase in referrals is in line with patterns in previous years and should this continue it can be expected that referrals will rise as the year progresses and we will receive more external referrals than the expected number of 69931.The annual outturn for 2014/15 was 69,920.

Trust Dashboard Graphs for TRUST

24) Delivery of our financial plan (I and E)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
24) Delivery of our financial plan (I and E)	-1,098,000.00	-4,709,000.00	NA	NA	NA	NA	NA	NA	NA	NA

Narrative
The Trust position for September 2015 is a surplus of £1,098,000 which is £301,000 better that the expected surplus of £797,000. The Trust position for the financial year to date is a surplus of £4,709,000, which is £537,000 above target. Based on performance during this financial year to date, it is anticipated that we will achieve the annual target of a surplus of £4,784,000.Data only started to be collected from April 2015; therefore no comparative data for 2014/15 is available.

Trust Dashboard - Locality Breakdown for TRUST

Strategic Goal 1: To provide excellent services, working with the individual users of our services and their carers to promote recovery and well being

	September 2015										April 2015 To September 2015									
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	98.00%	81.45%	98.00%	77.90%	98.00%	88.72%	98.00%	70.43%	98.00%	99.62%	98.00%	81.65%	98.00%	77.37%	98.00%	88.73%	98.00%	74.27%	98.00%	99.83%
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	98.00%	84.26%	98.00%	73.10%	98.00%	91.34%	98.00%	91.01%	98.00%	45.16%	98.00%	87.30%	98.00%	83.28%	98.00%	91.74%	98.00%	89.57%	98.00%	50.68%
3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral.	50.00%	74.29%	50.00%	60.00%	50.00%	78.95%	50.00%	83.33%	NA	NA	50.00%	73.70%	50.00%	61.21%	50.00%	81.02%	50.00%	81.82%	NA	NA
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	75.00%	83.59%	75.00%	98.44%	75.00%	53.78%	75.00%	72.26%	NA	NA	75.00%	81.04%	75.00%	98.43%	75.00%	59.38%	75.00%	65.84%	NA	NA
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	95.00%	92.03%	95.00%	100.00%	95.00%	78.99%	95.00%	84.67%	NA	NA	95.00%	93.62%	95.00%	99.84%	95.00%	79.13%	95.00%	91.85%	NA	NA
6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)	15.00%	13.08%	15.00%	12.83%	NA	NA	15.00%	13.47%	NA	NA	15.00%	13.33%	15.00%	12.73%	NA	NA	15.00%	14.24%	NA	NA
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	50.00%	44.32%	50.00%	44.50%	50.00%	40.17%	50.00%	45.97%	NA	NA	50.00%	46.45%	50.00%	44.89%	50.00%	45.96%	50.00%	49.21%	NA	NA
8) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post-validated	95.00%	96.30%	95.00%	94.44%	95.00%	96.30%	95.00%	97.78%	NA	NA	95.00%	97.53%	95.00%	96.98%	95.00%	97.57%	95.00%	98.07%	NA	NA
9) Percentage CPA 7 day follow up (AMH) - post-validated	95.00%	98.86%	95.00%	97.37%	95.00%	100.00%	95.00%	100.00%	NA	NA	95.00%	97.84%	95.00%	98.33%	95.00%	98.32%	95.00%	96.12%	NA	NA
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	98.53%	98.00%	98.02%	98.00%	99.61%	98.00%	98.05%	98.00%		98.00%	98.53%	98.00%	98.02%	98.00%	99.61%	98.00%	98.05%	98.00%	
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	85.00%	90.57%	85.00%	91.72%	85.00%	90.00%	85.00%	89.23%	85.00%	100.00%	85.00%	89.70%	85.00%	89.82%	85.00%	90.08%	85.00%	88.93%	85.00%	95.00%

Trust Dashboard - Locality Breakdown for TRUST

Strategic Goal 2: To continuously improve the quality and value of our work

	September 2015										April 2015 To September 2015									
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	7.23%	15.00%	5.43%	15.00%	7.95%	15.00%	8.70%	NA	NA	15.00%	16.00%	15.00%	17.67%	15.00%	7.24%	15.00%	25.46%	NA	NA
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	15.00%	27.17%	15.00%	12.00%	15.00%	36.11%	15.00%	30.00%	NA	NA	15.00%	25.11%	15.00%	23.19%	15.00%	22.62%	15.00%	30.00%	NA	NA
14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	17.00	36.00	6.00	10.00	6.00	15.00	7.00	11.00	NA	NA	105.00	145.00	33.00	50.00	33.00	43.00	40.00	51.00	NA	NA
15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	146.00	80.00	146.00	136.00	146.00	106.00	146.00	73.00	NA	NA	146.00	111.00	146.00	129.00	146.00	139.00	146.00	80.00	NA	NA
16) Percentage of appointments cancelled by the Trust	0.67%	1.07%	0.67%	1.07%	0.67%	0.91%	0.67%	1.49%	0.67%	0.10%	0.67%	1.07%	0.67%	1.08%	0.67%	1.01%	0.67%	1.31%	0.67%	0.06%
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.00	1.00	0.00	1.00	0.00	1.00	0.00	1.00	0.00	6.00	0.00	6.00	0.00	6.00	0.00	6.00	0.00	6.00	0.00
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	75.00%	79.07%	75.00%	81.82%	75.00%	100.00%	75.00%	77.78%	75.00%	58.33%	75.00%	72.96%	75.00%	84.29%	75.00%	88.52%	75.00%	72.09%	75.00%	35.29%

Trust Dashboard - Locality Breakdown for TRUST

Strategic Goal 3: To recruit, develop and retain a skilled, compassionate and motivated workforce

	September 2015										April 2015 To September 2015									
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
19) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	85.33%	95.00%	82.18%	95.00%	86.06%	95.00%	85.66%	95.00%	89.31%	95.00%	85.33%	95.00%	82.18%	95.00%	86.06%	95.00%	85.66%	95.00%	89.31%
20) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	90.38%	95.00%	88.90%	95.00%	91.45%	95.00%	86.46%	95.00%	91.59%	95.00%	90.38%	95.00%	88.90%	95.00%	91.45%	95.00%	86.46%	95.00%	91.59%
21) Percentage Sickness Absence Rate (month behind)	4.50%	4.21%	4.50%	4.21%	4.50%	4.45%	4.50%	3.84%	4.50%	5.51%	4.50%	4.51%	4.50%	4.42%	4.50%	4.78%	4.50%	4.33%	4.50%	6.14%

Trust Dashboard - Locality Breakdown for TRUST

Strategic Goal 5: To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve

	September 2015										April 2015 To September 2015									
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
22) Number of reds on CQC action plans (including MHA action plans)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
23) Total number of External Referrals into the Trust Services	5,747.00	6,311.00	1,876.00	1,837.00	1,922.00	2,043.00	1,767.00	1,785.00	183.00	607.00	35,061.00	36,702.00	11,447.00	11,234.00	11,719.00	12,024.00	10,779.00	10,856.00	1,117.00	2,544.00
24) Delivery of our financial plan (I and E)	-797,000.00	-1,098,000.00	NA	NA	NA	NA	NA	NA	NA	NA	-4,172,000.00	-4,709,000.00	NA	NA	NA	NA	NA	NA	NA	NA

MONITOR QUARTERLY SCORECARD - 2015/16

Indicator	Target	Quarter 1	Quarter 2
Percentage CPA 7 day follow up (AMH only) (post validated position)	95%	97.82%	97.57%
Percentage of CPA Patients having a formal review documented within 12 months (AMH only)	95%	98.35%	98.53%
Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (AMH only) (post validated position)	95%	97.65%	97.24%
Percentage of non acute patients whose transfer of care was delayed	7.50%	1.86%	1.88%
Data completeness: outcomes	90%	94.36%	94.47%
Data completeness: identifiers	99%	99.67%	99.71%
Access to Healthcare	100%	100.00%	100.00%
Number of EIP new cases	100%	261.54%	259.23%

Please note: the Q1 position is reported as at the 30th June 2015 and the Q2 position as at the 30th September 2015.

Appendix 2

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at December 2014*	Percentage	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1				
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined				
1	Percentage of patients who have not waited longer than 4 weeks for a first appointment	5						4				5					14	93%	93%	
2	Percentage of patients who have not waited longer than 4 weeks following an internal referral	5						4				5					14	93%	93%	
3	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral	5							3			5					13	n/a	87%	The Trust have developed a local KPI pending publication of national construction. There is an issue identified with allocation of a care co-ordinator which was required for this indicator, this is being looked at through the Data Quality group, but has temporarily been removed from the logic.
4	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral		4					4				5					13	n/a	87%	
5	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral		4					4				5					13	n/a	87%	
6	Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)		4					4				5					13	87%	87%	
7	Recovery Rate – Adult IAPT: The percentage of people who complete treatment who are moving to recovery		4					4				5					13	87%	87%	
8	Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only)		4					4				5					13	80%	87%	Data is now imported back into IIC following manual validation. This increases reliability; however, there will be some discharges discounted because complete validation has not been possible within the time. These could subsequently be determined to be breaches.
9	Percentage CPA 7 day follow up (adult services only)		4					4				5					13	80%	87%	Data is now imported back into IIC following manual validation. This increases reliability; however, there will be some discharges discounted because complete validation has not been possible within the time. These could subsequently be determined to be breaches.
10	Percentage of CPA Patients having a formal review documented within 12 months – snapshot (adult services only)	5						4				5					14	87%	93%	
11	Percentage of community patients who state they have been involved in the development of their care plan (month behind)					1		4				5					10	67%	67%	Surveys are manual for community although some hand held for ALD. The surveys are sent to a team in Flatts Lane who input the scores from each paper survey into an excel spreadsheet. They send the spreadsheet to CRT who supply community based reports. The plan is to follow the same process as the ward from this point onwards.
12	Percentage of out of locality admissions to assessment and treatment wards (AMH and MHSOP) - post validated		4					4				5					13	n/a	87%	
13	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	5						4				5					14	n/a	93%	
14	Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	5					5					5					15	n/a	100%	

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at December 2014*	Percentage	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1				
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined				
15	Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	5					5					5					15	n/a	100%	
16	Percentage of appointments cancelled by the Trust	5									1	5					11	n/a	73%	Whilst data reliability has been tested, a number of data quality issues identified by the Patient Experience Group and the localities have raised a significant concern; therefore the Data Quality Group has assessed reliability at 1. For example: • appointments being incorrectly recorded as cancelled • not all cancelled appointments being recorded • appointments not having outcomes recorded A working party is to be established to investigate the problem and produce longer term recommendations
17	Number of unexpected deaths classed as a serious incident per 10,000 open cases					1		4				5					10	60%	67%	Different sources in calculation - lower one used which is a manual process including a telephone call and data entered onto a spreadsheet (unexpected deaths)
18	Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)			3				4				5					12	73%	80%	The devices are uploaded electronically (can sometimes be issues with the devices) direct to CRT. Patient Experience Team (PET) provided with ward based reports. PET open every ward report, identify the % and number completing, calculate the numerator manually then type this
19	Mean level of improvement on SWEMWBS (AMH Only)	5					5					5					15	100%	100%	
20	Mean level of improvement on SWEMWBS (MHSOP Only)	5					5					5					15	100%	100%	
21	Percentage HONOS ratings that have improved in the non-psychotic and psychosis super classes for patients that are in scope (AMH and MHSOP)	5						4				5					14	93%	93%	
22	Percentage of HONOS ratings that have improved in the organic super classes for patients that are in scope (AMH and MHSOP)	5						4				5					14	93%	93%	
23	Percentage of staff in post more than 12 months with a current appraisal – snapshot	5						4				5					14	93%	93%	
24	Percentage compliance with mandatory and statutory training – snapshot	5						4				5					14	93%	93%	
25	Percentage Sickness Absence Rate (month behind)	5							3			5					13	87%	87%	Audit findings have highlighted issues with the accuracy of data: • Discrepancies between ESR and paper records • Sickness periods not being recorded • Sickness episodes not being closed
26	Number of reds on CQC Action Plans (including MHA Action Plans)					1	5					5					11	67%	73%	Static reports are emailed to the Trust. Data is then manually transferred from the reports into an Excel spreadsheet, which is then manually monitored to ensure all actions are green.
27	Total number of External Referrals into the Trust Services	5					5					5					15	100%	100%	
28	Are we delivering our financial plan (I and E)		4				5					5					14	n/a	93%	

* A comparative figure for December 2014 will only be available for those KPIs that were reported during the 2014/15 financial year

Number of unexpected deaths and verdicts from the coroner April 2015-September 2015

	Number of unexpected deaths in the community				Number of unexpected deaths of patients who are an inpatient and took place in the hospital				Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital				Number of unexpected deaths where the patient was no longer in service				Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	Durham & Darlington	Teesside	North Yorkshire	Forensics	Durham & Darlington	Teesside	North Yorkshire	Forensics	Durham & Darlington	Teesside	North Yorkshire	Forensics	
Accidental death	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Natural causes	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Hanging	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Suicides	4	1	3	0	0	0	0	0	0	0	0	0	0	1	0	0	**9**
Open	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Abuse of drugs	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**3**
Drowning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Misadventure	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Awaiting verdict	8	4	6	0	0	0	0	0	2	1	3	0	1	3	1	1	**30**
Total	**15**	**7**	**11**	**0**	**0**	**0**	**0**	**0**	**2**	**1**	**3**	**0**	**1**	**4**	**1**	**1**	**46**

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
7	10	9	11	5	4						

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

Number of unexpected deaths and verdicts from the coroner 2014 / 2015

	Number of unexpected deaths in the community				Number of unexpected deaths of patients who are an inpatient and took place in the hospital				Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital				Number of unexpected deaths where the patient was no longer in service				Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	Durham & Darlington	Teesside	North Yorkshire	Forensics	Durham & Darlington	Teesside	North Yorkshire	Forensics	Durham & Darlington	Teesside	North Yorkshire	Forensics	
Accidental death	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Natural causes	1	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	**3**
Hanging	1	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	**4**
Suicides	14	8	3	1	0	0	0	1	0	0	0	0	1	3	2	0	**33**
Open	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Abuse of drugs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Drowning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Misadventure	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**2**
Awaiting verdict	6	1	3	0	1	1	0	0	1	0	0	0	3	1	0	0	**18**
Total	**22**	**11**	**8**	**1**	**1**	**1**	**0**	**1**	**2**	**0**	**0**	**0**	**7**	**4**	**3**	**0**	**61**

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
4	2	7	7	4	4	2	8	3	7	5	8

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

FOR GENERAL RELEASE **Item 13**

BOARD OF DIRECTORS

Date of Meeting: **27th OCTOBER 2015**

Title: **TRUST WORKFORCE REPORT**

Lead Director: **David Levy**

Report for: **Information**

This report includes/supports the following areas:

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

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

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

BOARD OF DIRECTORS

Date of Meeting: 27th OCTOBER 2015

Title: TRUST WORKFORCE REPORT

1. INTRODUCTION & PURPOSE

1.1 The purpose of this report is to provide the Board of Directors with information concerning key workforce performance, primarily in respect of the period July to September 2015 (Appendix 1). Information about medical staffing issues is included (Appendix 2) as is a copy of the 2015/16 Q2 Staff Friends and Family test results (Appendix 3).

.

2. BACKGROUND INFORMATION

2.1 Information within the Quarterly Workforce Report is also shared with the Executive Management Team, the Workforce and Development Group and the Joint Consultative Committee.

3. KEY ISSUES:

3.1 The number of staff in post, the extent of use of fixed term contracts and the labour turnover rate remained largely stable during the last two quarters. The age profile of the workforce and the proportion of leavers accounted for by age retirement continue to represent a potential risk to workforce supply. Some 39% of retirees chose to return to work during the last twelve months and with increasing numbers of age retirements anticipated over the next three years further consideration is being given to encouraging more staff to retire and return to work. The use of an electronic exit questionnaire is being considered as part of efforts to improve our understanding of what is meant when the reason for leaving is given as Voluntary resignation – Other/unknown.

3.2 Sickness absence rates during the period April to August 2015 compared well with the equivalent period in previous years and this reporting period traditionally sees the lowest sickness absence rates in the year. The revised Sickness Absence Management Procedure continues to be implemented and a range of staff health and wellbeing initiatives are on-going.

3.3 The time taken to conclude disciplinary investigations increased markedly with only 12% of cases being concluded within the 8 weeks target period compared to 67% in the previous quarter. A new central disciplinary investigation team began work in the middle of October with the aim of reducing the time taken to complete disciplinary investigations whilst maintaining the quality of investigations. Some 79% of concluded grievances were completed within the target time period of three months. The number of on-going grievances, there are five at present, is low compared to previous reporting periods.

3.4 Completion of annual appraisal fell during the reporting period, with the exceptions of Forensic Services and Corporate Services, compared to the previous quarter though the rate was slightly higher than during the equivalent period in 2014. A revised appraisal system has been developed and is to be implemented across the Trust over the next eighteen months. The aim is to improve both the quality and quantity of appraisal activity. There was an across the board increase in the completion of mandatory and statutory training from 87% to 90%, compared to the previous quarter.

3.5 The percentage of new staff completing corporate induction within 8 weeks of joining the Trust rose from 85% to 90% and feedback from new starters about the corporate induction day continues to be positive. An issue that has been present since the corporate induction programme was reduced from two days to one day last year is that fewer new staff are completing their core mandatory and statutory training within 8 weeks of joining the Trust. Since last year efforts have been regularly made to remind new staff and their managers of the need to complete mandatory training within 8 weeks of joining the Trust and these efforts will continue however, alternative courses of action are now being considered. One option is to simply add a second day of corporate induction which could be dedicated to mandatory training. A further option is to develop a new approach to new starters whereby all new starters complete their a corporate induction programme, including access to systems such as ESR, health-roster and PARIS and mandatory training, before they begin working in the Trust. Such an approach would have a number of benefits, including 100% completion of core mandatory training. The Workforce and Development Group will consider this matter before a related paper is taken to the Executive Management Team.

3.6 The time taken to recruit to vacant posts increased compared to the previous quarter. Bands 1 to 5 posts took on average 16 weeks to fill compared to a target of 13 weeks and Bands 6 to 9 posts took on average 17 weeks to fill compared to a target of 15 weeks. A service improvement event was held earlier this month to develop a new approach to recruitment that will reduce the time taken to recruit and that will increase the number of applicants. The outcomes of the event are to be presented to the Executive Management Team next month. The Quality Assurance Committee received a detailed report about recruitment at its October meeting. The report stated that the overall post fill rate is 92% and that there is evidence of some posts being particularly hard to fill. As more staff become eligible to retire over the next three to five years the risk to future workforce supply increases. At the recently held Board business planning workshop the production of a Trust-wide Recruitment Plan was proposed and, subject to further consultation, the plan will be developed.

3.7 the number of staff within the redeployment service reduced markedly during the last quarter compared to numbers reported during the previous year. The proportion of staff being successfully redeployed reduced compared to the previous quarter though this is believed to be due to the number of staff in redeployment due to health reasons rather than because of organisational change.

3.8 The professional registration checking and follow up process is working well.

3.9 Appendix 3 provides information about the latest set of Staff Friends and Family Test (Staff FFT) results, representing the views of some 2,600 staff. The latest

results, the fifth set to be received, are similar to those previously reported with no statistically significant changes identified. The intention is to take steps to better understand the actions that are being taken by teams in response to the feedback provided and to liaise with the Patient Experience Team to compare this information with Patient Friends and Family Test results. Over 200 hundred teams regularly receive team Staff FFT results though a further 100 teams do not due to their small size i.e. they have less than five team members. There is some evidence that those teams with more positive Staff FFT results may undertake more action planning and delivery activities than those with poorer results however, the position needs to be further explored with teams before we can draw any firm conclusions. The response rate of the most recent Staff FFT was down at 49.7% compared to the previous rate of 54.8%. Ensuring that team results are being shared and acted upon will be important in the future if this particular means of enhancing staff engagement is to be successful.

4. IMPLICATIONS / RISKS:

4.1 Quality: There is growing evidence that improving people management policy and practice can have a positive impact upon the quality of services provided.

4.2 Financial: None identified.

4.3 Legal and Constitutional: None identified.

4.4 Equality and Diversity: Each of the key workforce performance indicators requires that a positive approach is taken toward equality and diversity issues.

4.5 Other Risks: None identified.

5. CONCLUSIONS

5.1 A mixed picture though the Staff FFT results are encouraging.

5.2 The report highlights a number of related pieces of work being undertaken.

6. RECOMMENDATIONS

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

David Levy
Director of Human Resources and Organisational Development

Background Papers:
Please list any source documents used in the preparation of the report.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

APPENDIX 1

HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT DIRECTORATE

QUARTERLY WORKFORCE REPORT KEY PERFORMANCE INDICATORS JULY – SEPTEMBER 2015

1.0 INTRODUCTION

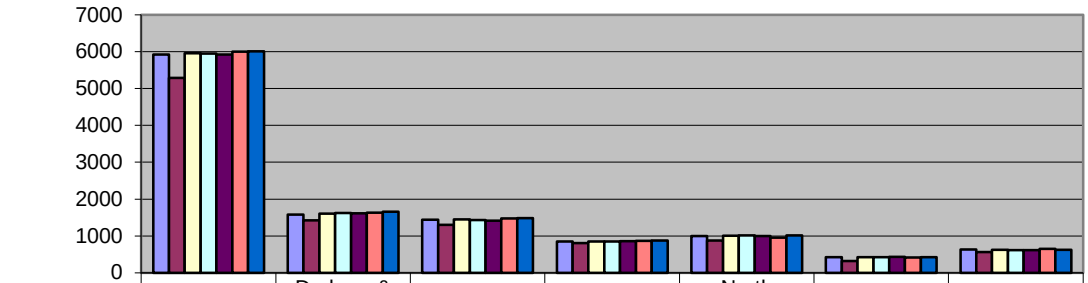
This report provides information about key workforce performance during the last quarter, July to September 2015.

2.0 Staff in Post

Figure 1 shows the staff in post position during the last quarter.

- The total Trust workforce has reduced by 1.26% over the last 12 months**.** In the last quarter the workforce has decreased marginally by 30 to 5925.

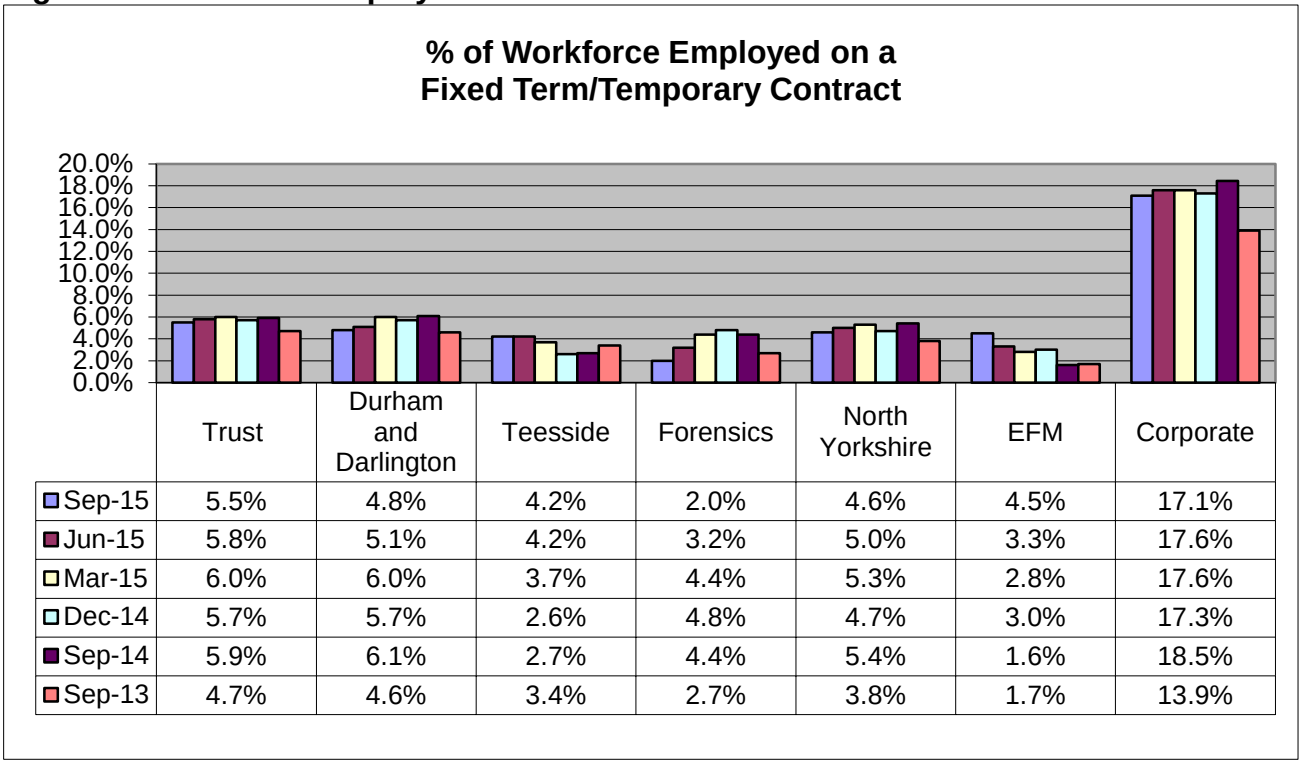
Figure 1 Staff in Post



	Trust	Durham & Darlington	Teesside	Forensics	North Yorks	EFM	Corporate
Sep-15	5925	1580	1442	849	1001	426	629
Sept15 wte	5287.6	1418.7	1299.3	809.1	877.1	320.6	562.9
Jun-15	5955	1604	1450	847	1008	424	622
Mar-15	5950	1623	1428	846	1016	426	611
Dec-14	5924	1611	1411	862	1000	429	611
Sep-14	6001	1631	1478	869	955	416	652
Sep-13	6007	1654	1486	877	1015	421	624

Figure 2 highlights the number of staff employed on a fixed term/temporary contract as a percentage of the total number of staff employed. Corporate Services continue to have the highest percentage of staff employed on a fixed term/temporary contract, due to the use of project-related posts.

Figure 2 Fixed Term Employment

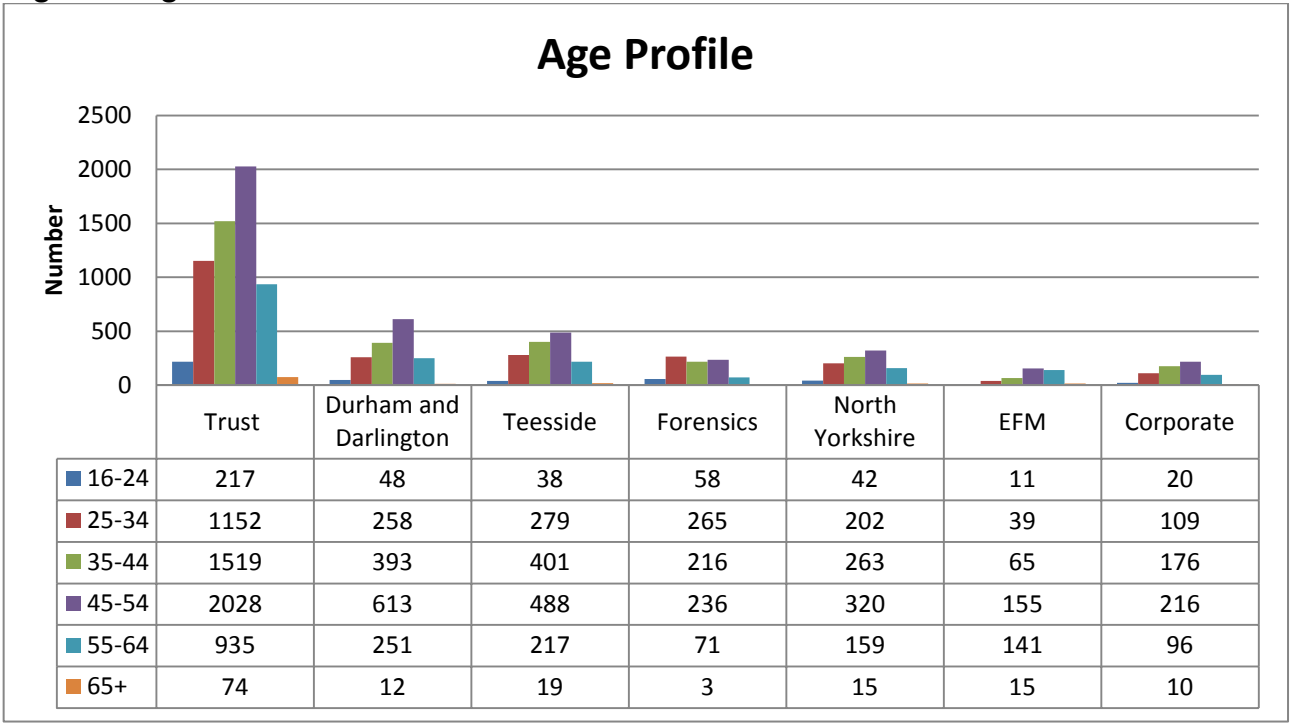


	Trust	Durham and Darlington	Teesside	Forensics	North Yorkshire	EFM	Corporate
Sep-15	5.5%	4.8%	4.2%	2.0%	4.6%	4.5%	17.1%
Jun-15	5.8%	5.1%	4.2%	3.2%	5.0%	3.3%	17.6%
Mar-15	6.0%	6.0%	3.7%	4.4%	5.3%	2.8%	17.6%
Dec-14	5.7%	5.7%	2.6%	4.8%	4.7%	3.0%	17.3%
Sep-14	5.9%	6.1%	2.7%	4.4%	5.4%	1.6%	18.5%
Sep-13	4.7%	4.6%	3.4%	2.7%	3.8%	1.7%	13.9%

- **figures exclude doctors in training and trainee clinical psychologists**

Figure 3 highlights the age profile of the Trust. Analysis shows 51.3% of staff aged between 44 and over 65. This trend is comparable within Teesside, North Yorkshire Localities and Corporate Services. The figure increases to 55.6% in Durham and Darlington and is considerably lower in Forensic Services at 36.5%. The figure is significantly higher in Estates and Facilities Management at 73.0%

Figure 3 Age Profile

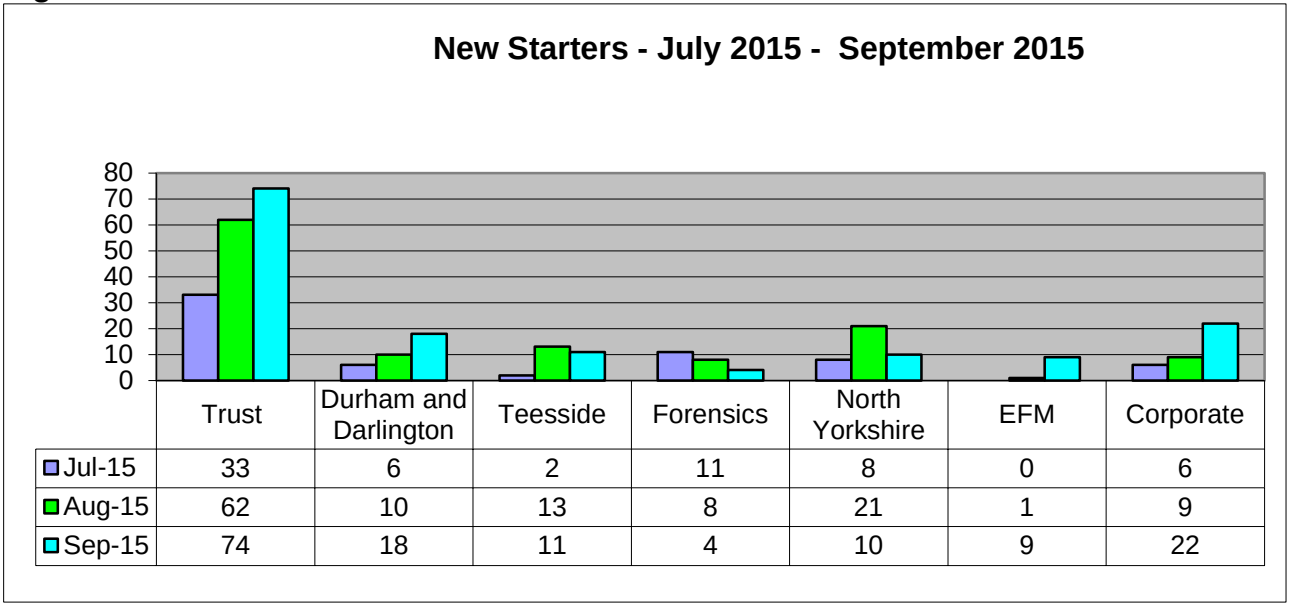


	Trust	Durham and Darlington	Teesside	Forensics	North Yorkshire	EFM	Corporate
16-24	217	48	38	58	42	11	20
25-34	1152	258	279	265	202	39	109
35-44	1519	393	401	216	263	65	176
45-54	2028	613	488	236	320	155	216
55-64	935	251	217	71	159	141	96
65+	74	12	19	3	15	15	10

4.0 New Starters

Figure 4 highlights the number of new starters within the Trust during the last quarter. There were a total of 169 new starters during the quarter compared to 134 reported in the previous quarter.

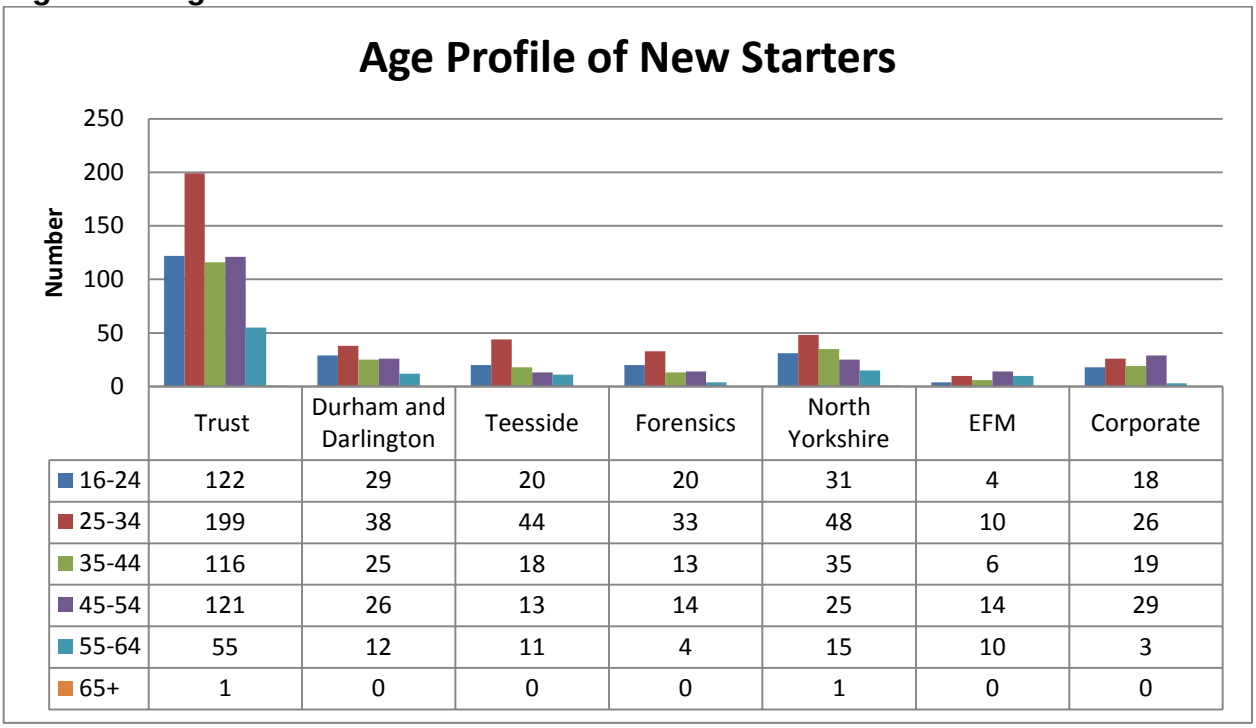
Figure 4 New Starters



	Trust	Durham and Darlington	Teesside	Forensics	North Yorkshire	EFM	Corporate
Jul-15	33	6	2	11	8	0	6
Aug-15	62	10	13	8	21	1	9
Sep-15	74	18	11	4	10	9	22

Figures 5 shows an age profile of new starters over the last 12 months. Analysis highlights that 32.4% of new starters are aged between 25 and 34. This figures increases to 41.5% for Teesside and 39.3% in Forensic Services. The figure for Durham and Darlington is 29.2%. Estates and Facilities Management show 31.8% of new starters within the age range 45 – 54.

Figure 5 – Age Profile

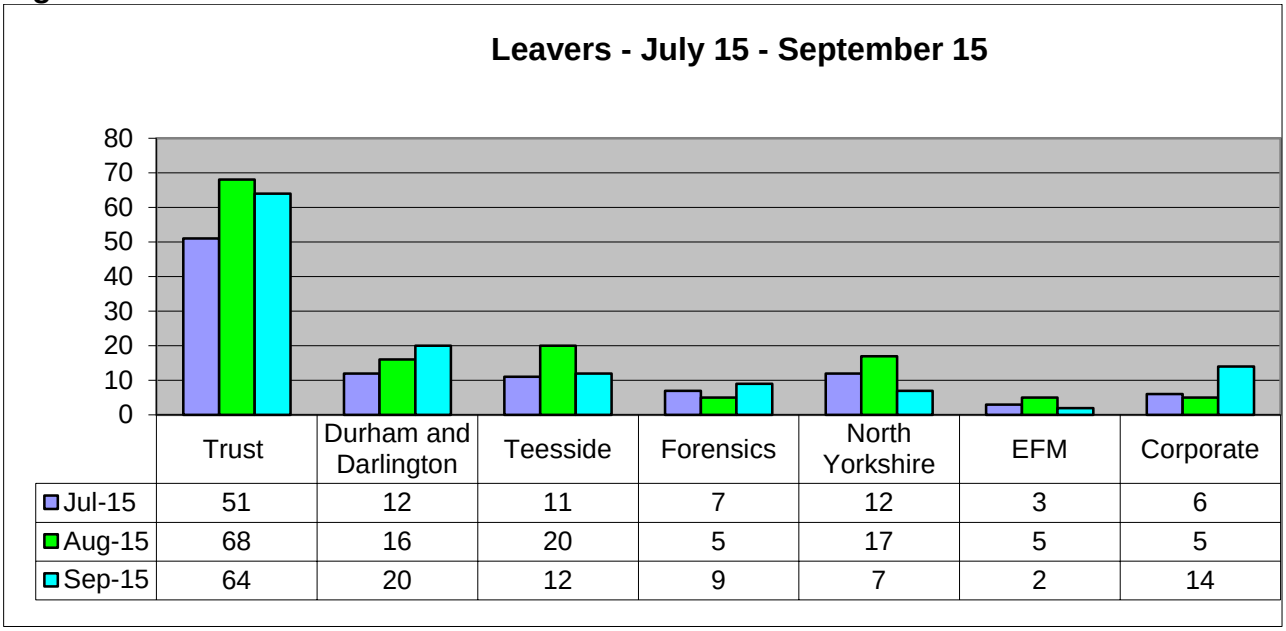


	Trust	Durham and Darlington	Teesside	Forensics	North Yorkshire	EFM	Corporate
16-24	122	29	20	20	31	4	18
25-34	199	38	44	33	48	10	26
35-44	116	25	18	13	35	6	19
45-54	121	26	13	14	25	14	29
55-64	55	12	11	4	15	10	3
65+	1	0	0	0	1	0	0

5.0 Leavers

Figure 6 shows the number of leavers during the last quarter.

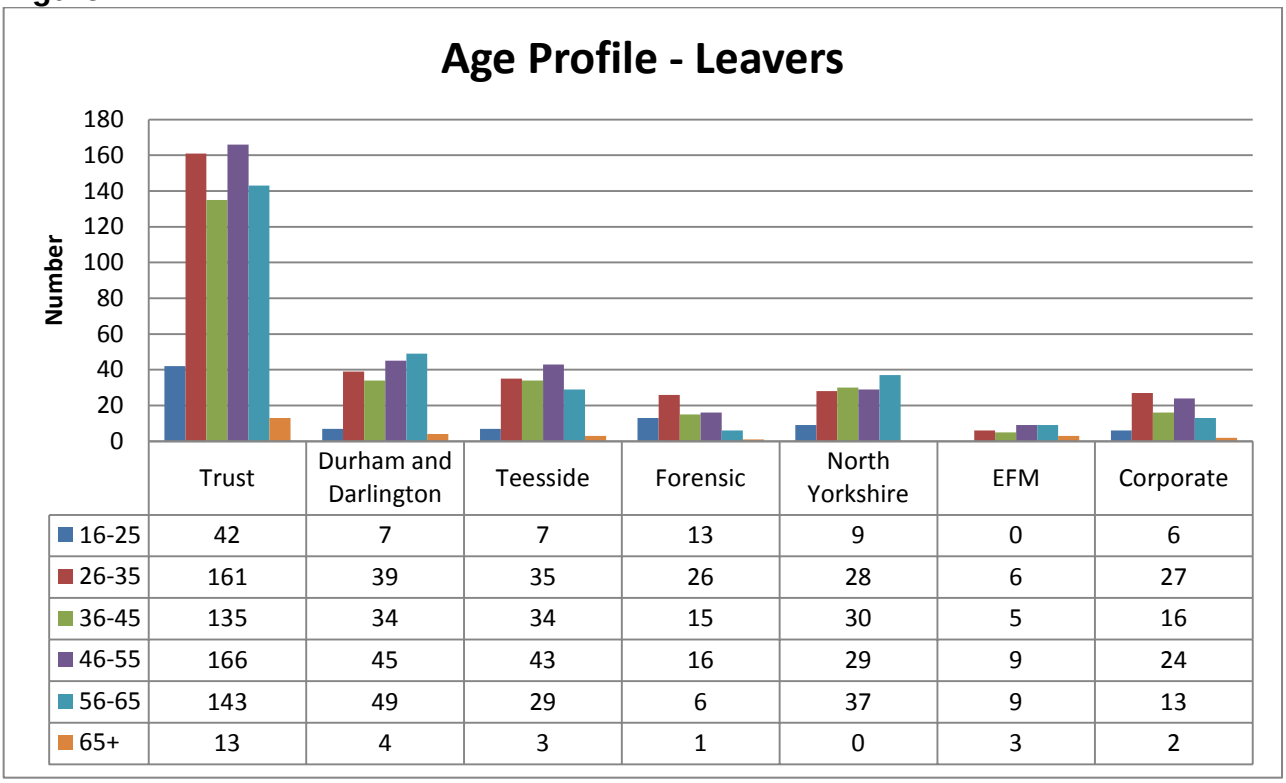
Figure 6 Leavers



	Trust	Durham and Darlington	Teesside	Forensics	North Yorkshire	EFM	Corporate
Jul-15	51	12	11	7	12	3	6
Aug-15	68	16	20	5	17	5	5
Sep-15	64	20	12	9	7	2	14

Figures 7 shows an age profile of leavers over the last 12 months. Analysis highlights that 25.2% of leavers were aged between 46 and 55, this figure increases to 28.5% in Teesside.

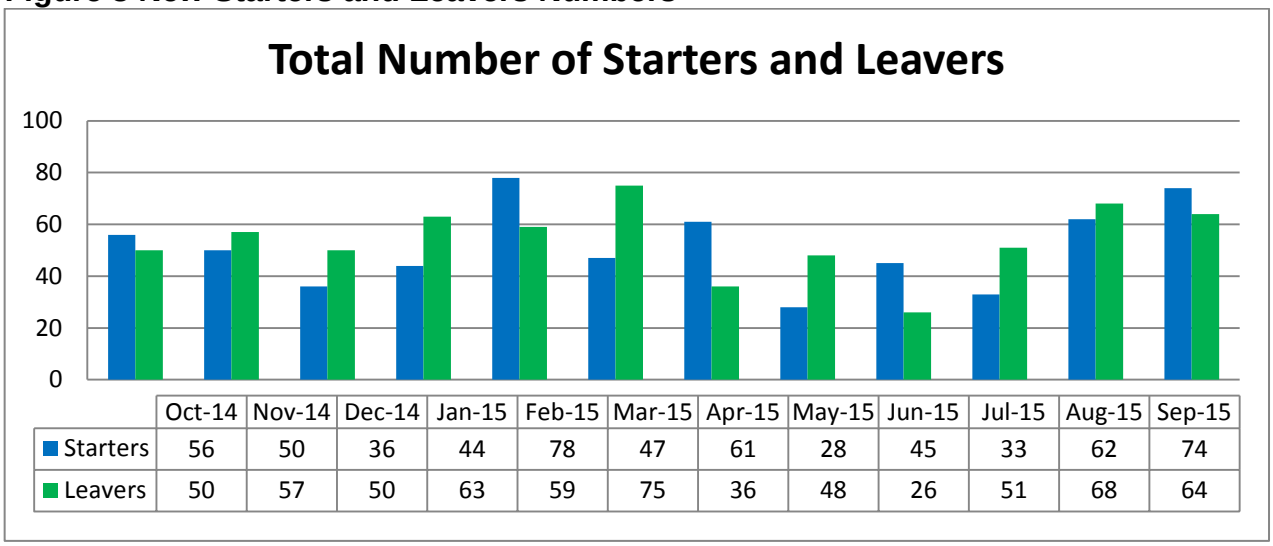
Figure7



	Trust	Durham and Darlington	Teesside	Forensic	North Yorkshire	EFM	Corporate
16-25	42	7	7	13	9	0	6
26-35	161	39	35	26	28	6	27
36-45	135	34	34	15	30	5	16
46-55	166	45	43	16	29	9	24
56-65	143	49	29	6	37	9	13
65+	13	4	3	1	0	3	2

Figure 8 shows the total number of starters and leavers during the period October 2014 to September 2015. The average number of starters over the last 12 month period has reduced to 51 per month. The average number of leavers over the last 12 month period has also reduced slightly to 54 per month.

Figure 8 New Starters and Leavers Numbers



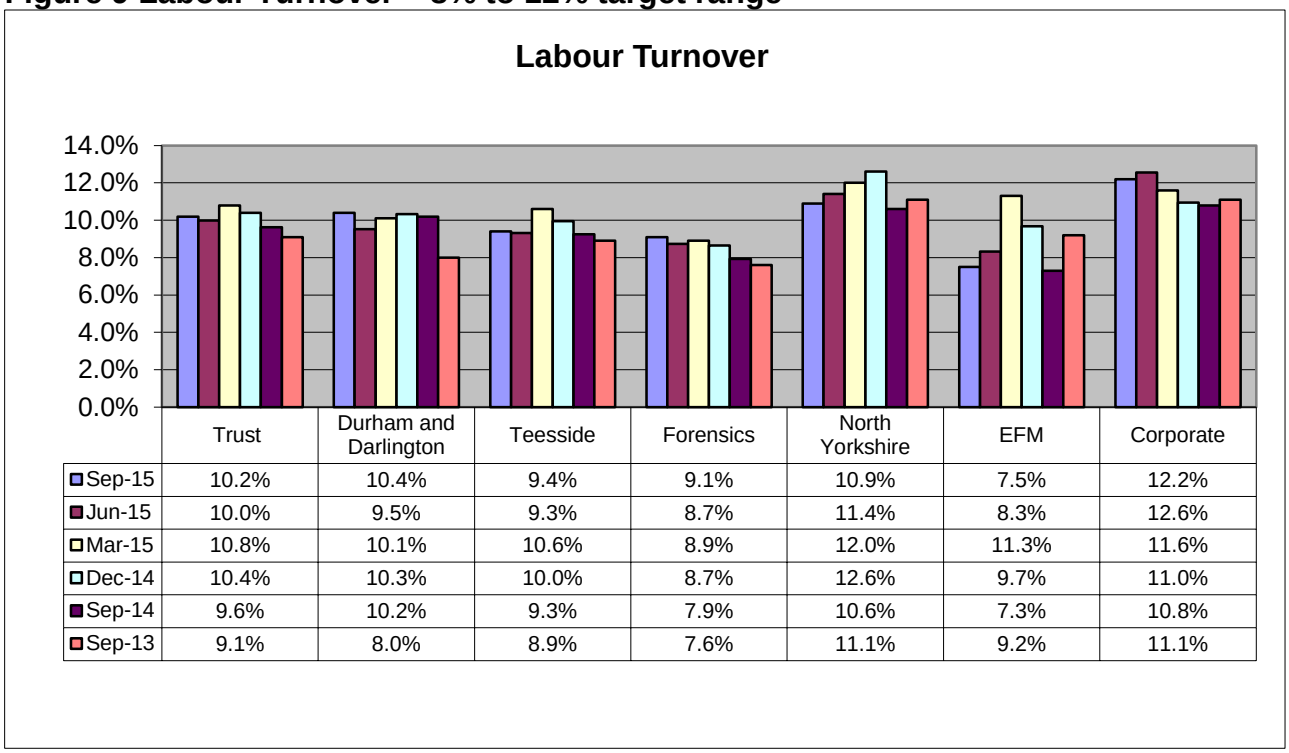
	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Starters	56	50	36	44	78	47	61	28	45	33	62	74
Leavers	50	57	50	63	59	75	36	48	26	51	68	64

6.0 Labour Turnover

Figure 9 provides information about labour turnover rates up to 30th September 2015. A total of 604 staff left the Trust during the last 12 months. The calculation **excludes doctors in training** that have left the Trust.

- 108 leavers were employed on a fixed term contract when their **employment with the Trust ended.**
- The Trust turnover rate falls to 8.4% when fixed term contract leavers are excluded from the labour turnover calculation.
- 38 members of staff chose to retire flexibly and return to the Trust after the requisite break in service.
- 101 members of staff left for reason of age related retirement and 14 voluntarily retired early.

Figure 9 Labour Turnover – 8% to 12% target range



	Trust	Durham and Darlington	Teesside	Forensics	North Yorkshire	EFM	Corporate
Sep-15	10.2%	10.4%	9.4%	9.1%	10.9%	7.5%	12.2%
Jun-15	10.0%	9.5%	9.3%	8.7%	11.4%	8.3%	12.6%
Mar-15	10.8%	10.1%	10.6%	8.9%	12.0%	11.3%	11.6%
Dec-14	10.4%	10.3%	10.0%	8.7%	12.6%	9.7%	11.0%
Sep-14	9.6%	10.2%	9.3%	7.9%	10.6%	7.3%	10.8%
Sep-13	9.1%	8.0%	8.9%	7.6%	11.1%	9.2%	11.1%

***figures exclude doctors in training.

The table below highlights analysis undertaken in to the **most prevalent reasons** for leaving the Trust over the last 12 months. The analysis excludes doctors in training and staff leaving with a reason of end of fixed term contract.

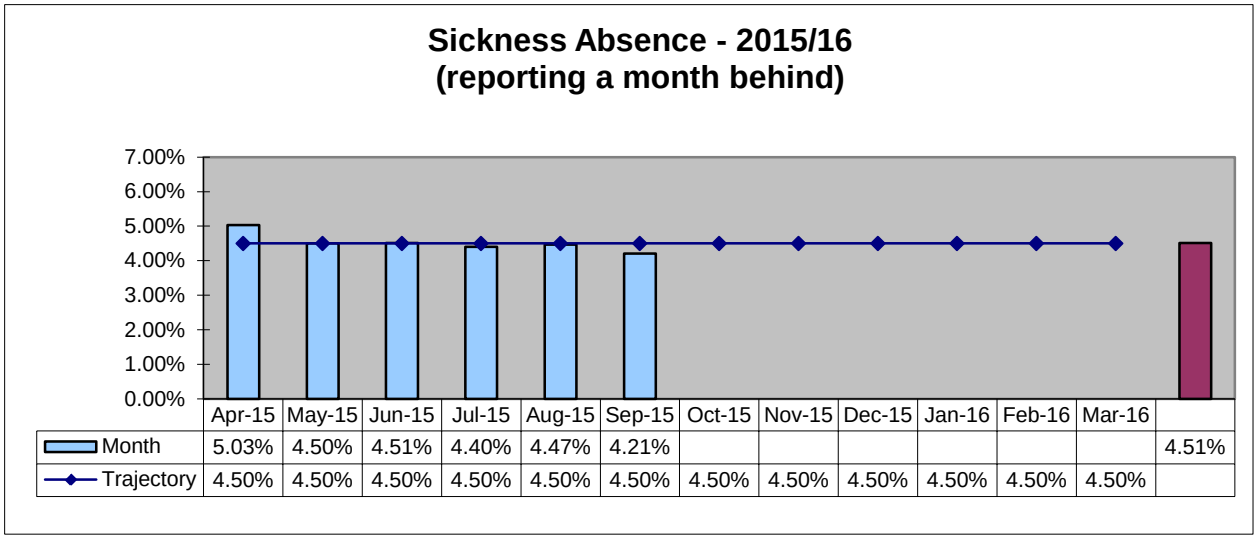
	Trust	Durham & Darlington	Teesside	Forensics	North Yorkshire	EFM	Corporate
Number of leavers	497	142	123	67	94	29	41
Age retirement	20.1%	26.1%	17.9%	4.5%	24.5%	17.2%	21.9%
Voluntary resignation – Other/ unknown	17.1%	11.3%	15.4%	32.8%	18.1%	13.8%	17.1%
Voluntary resignation -relocation	11.9%	12.0%	8.1%	17.9%	15.9%	10.3%	4.9%
Voluntary resignation -promotion	8.8%	7.7%	8.1%	7.5%	11.7%	0.0%	17.1%
Voluntary resignation – work-life balance	6.0%	4.2%	6.5%	3.0%	10.6%	6.9%	4.9%

The average length of service of staff leaving the Trust is 9 years.

7.0 Sickness Absence

Figure 10 provides details of performance compared to target

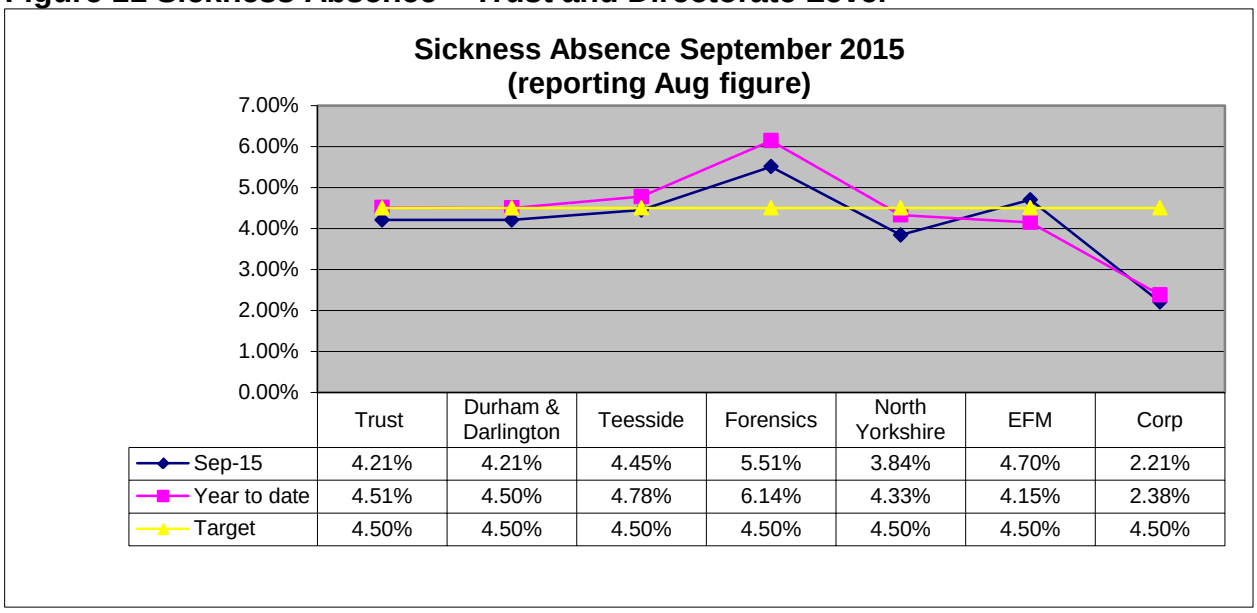
Figure 10 Total Sickness Absence 2015/16 – no more than 4.5%



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	
Month	5.03%	4.50%	4.51%	4.40%	4.47%	4.21%							4.51%
Trajectory	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	

Figure 11 provides sickness absence percentage rate information at Trust and directorate level. Variations between directorate rates are apparent.

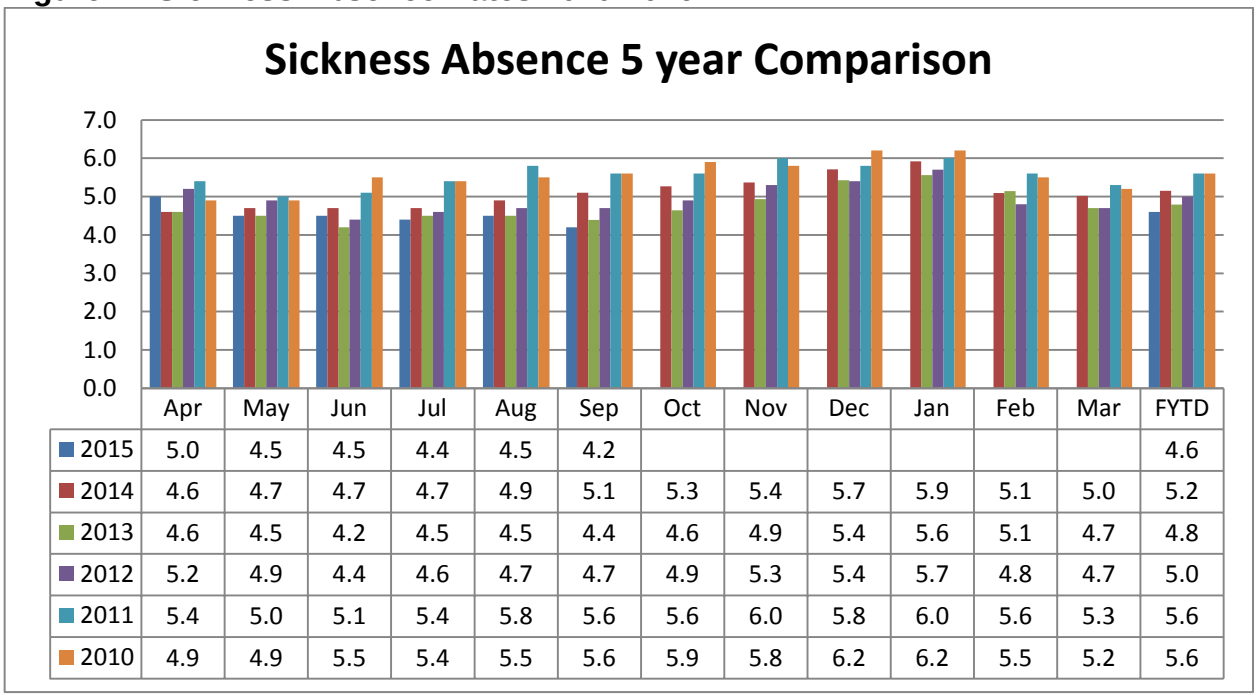
Figure 11 Sickness Absence – Trust and Directorate Level



	Trust	Durham & Darlington	Teesside	Forensics	North Yorkshire	EFM	Corp
Sep-15	4.21%	4.21%	4.45%	5.51%	3.84%	4.70%	2.21%
Year to date	4.51%	4.50%	4.78%	6.14%	4.33%	4.15%	2.38%
Target	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%

Figure 12 includes monthly sickness absence rates over the last five years.

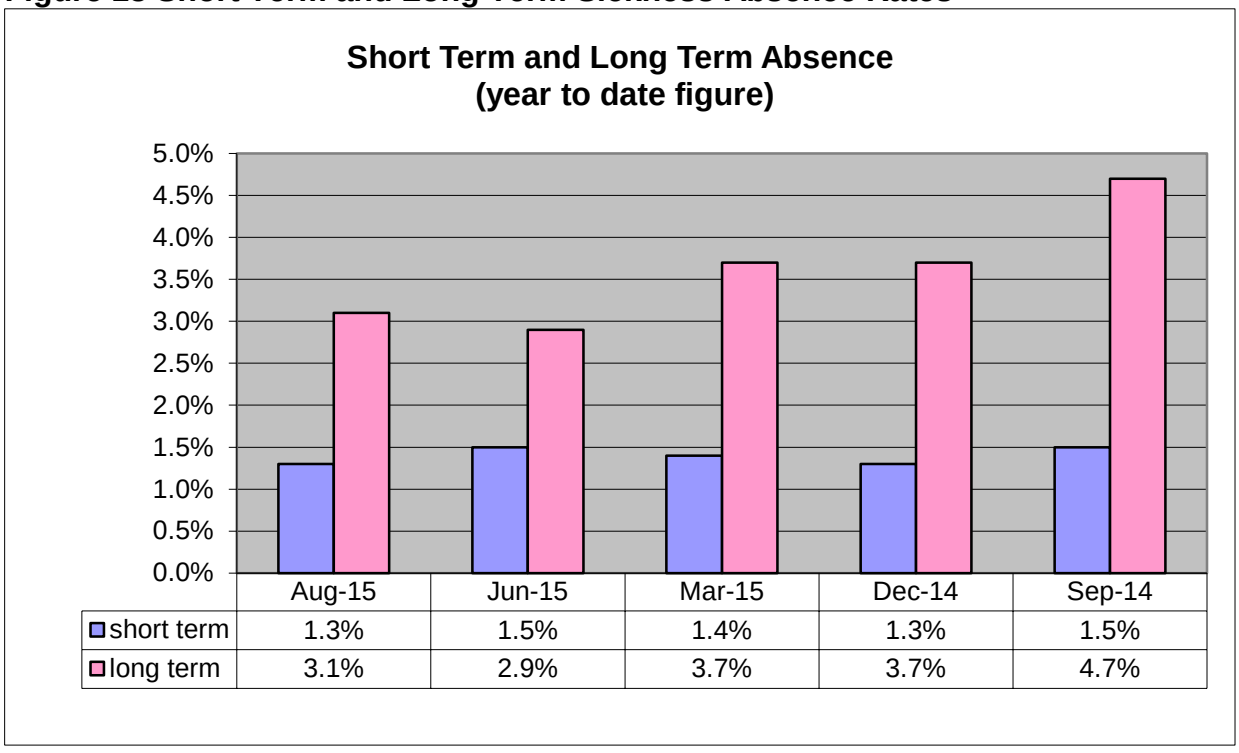
Figure 12 Sickness Absence Rates 2010-2016



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	FYTD
2015	5.0	4.5	4.5	4.4	4.5	4.2							4.6
2014	4.6	4.7	4.7	4.7	4.9	5.1	5.3	5.4	5.7	5.9	5.1	5.0	5.2
2013	4.6	4.5	4.2	4.5	4.5	4.4	4.6	4.9	5.4	5.6	5.1	4.7	4.8
2012	5.2	4.9	4.4	4.6	4.7	4.7	4.9	5.3	5.4	5.7	4.8	4.7	5.0
2011	5.4	5.0	5.1	5.4	5.8	5.6	5.6	6.0	5.8	6.0	5.6	5.3	5.6
2010	4.9	4.9	5.5	5.4	5.5	5.6	5.9	5.8	6.2	6.2	5.5	5.2	5.6

Figure 13 provides a breakdown of absence by short-term and long-term percentage rates between the period September 2014 and August 2015.

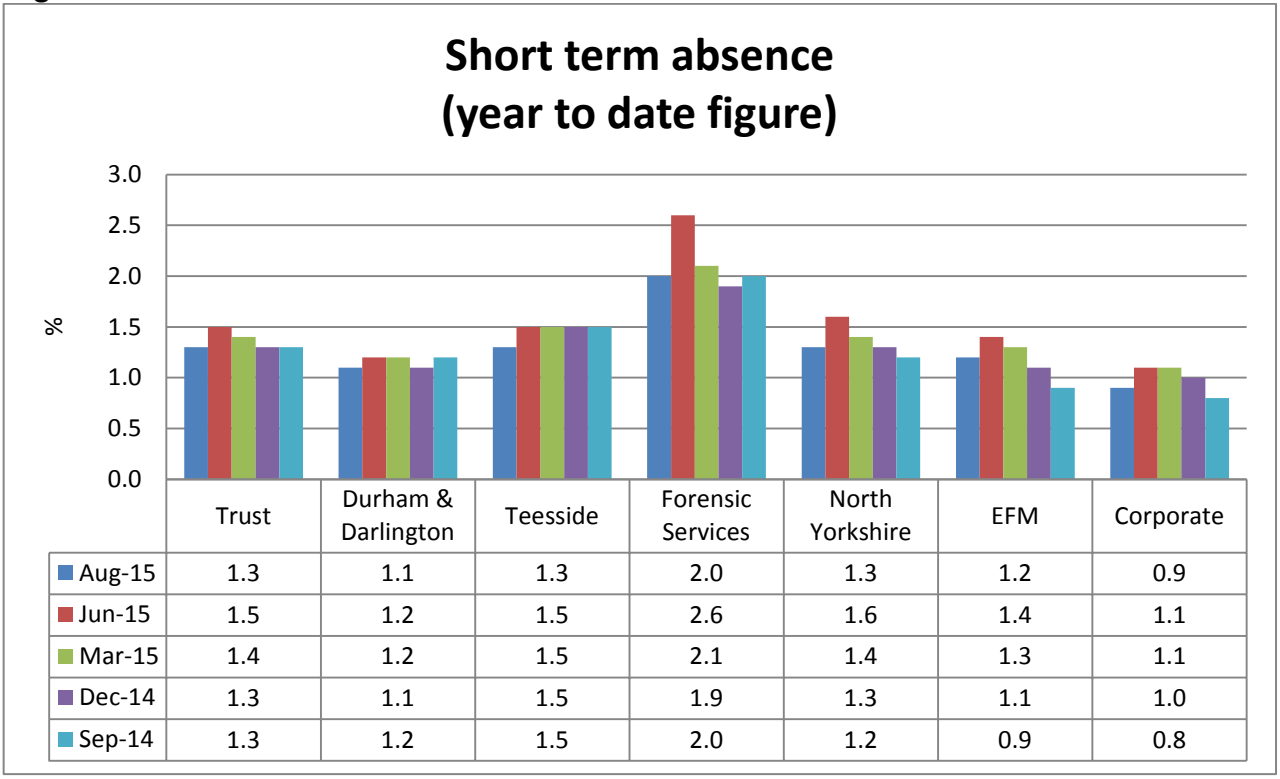
Figure 13 Short Term and Long Term Sickness Absence Rates



	Aug-15	Jun-15	Mar-15	Dec-14	Sep-14
short term	1.3%	1.5%	1.4%	1.3%	1.5%
long term	3.1%	2.9%	3.7%	3.7%	4.7%

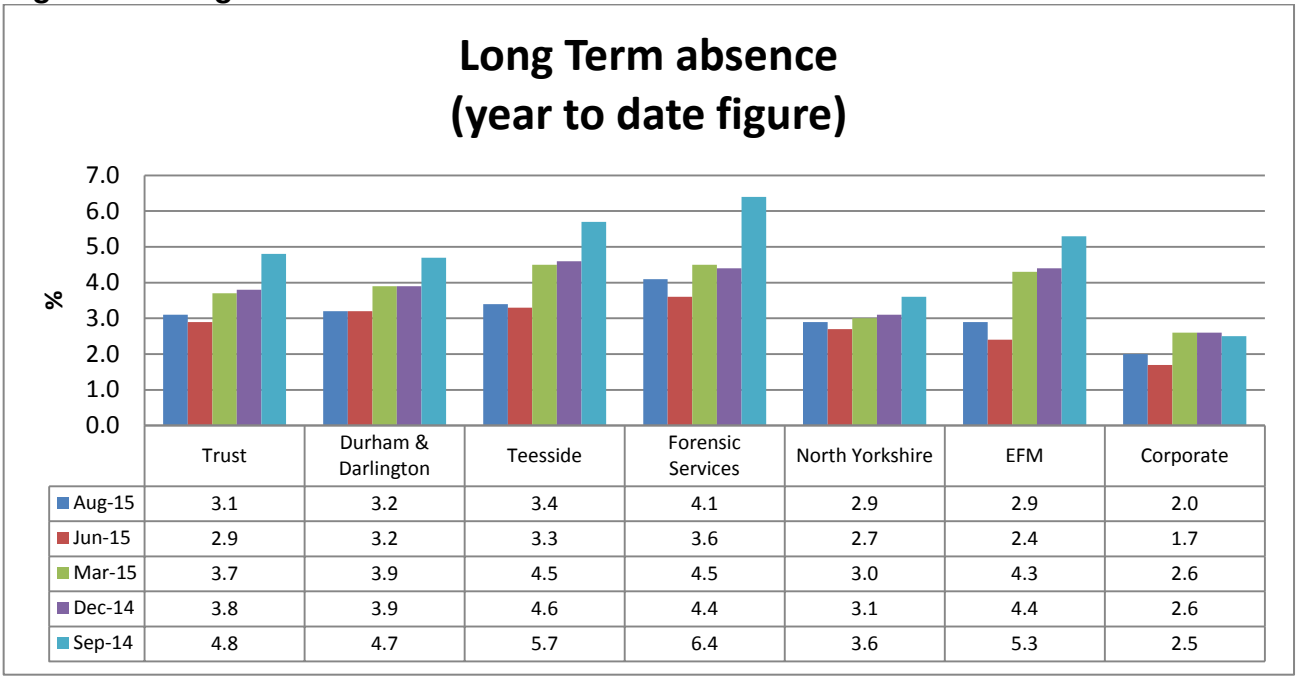
Figures 14 and 15 provide a breakdown of absence by short-term and long-term percentage rates respectively by locality from September 2014 to August 2015.

Figure 14 Short Term Sickness Absence – Trust and Directorate Level



	Trust	Durham & Darlington	Teesside	Forensic Services	North Yorkshire	EFM	Corporate
Aug-15	1.3	1.1	1.3	2.0	1.3	1.2	0.9
Jun-15	1.5	1.2	1.5	2.6	1.6	1.4	1.1
Mar-15	1.4	1.2	1.5	2.1	1.4	1.3	1.1
Dec-14	1.3	1.1	1.5	1.9	1.3	1.1	1.0
Sep-14	1.3	1.2	1.5	2.0	1.2	0.9	0.8

Figure 15 Long Term Sickness Absence – Trust and Directorate Level



	Trust	Durham & Darlington	Teesside	Forensic Services	North Yorkshire	EFM	Corporate
Aug-15	3.1	3.2	3.4	4.1	2.9	2.9	2.0
Jun-15	2.9	3.2	3.3	3.6	2.7	2.4	1.7
Mar-15	3.7	3.9	4.5	4.5	3.0	4.3	2.6
Dec-14	3.8	3.9	4.6	4.4	3.1	4.4	2.6
Sep-14	4.8	4.7	5.7	6.4	3.6	5.3	2.5

8.0 Employee Relations

Disciplinary Episodes

There were a total of nineteen concluded disciplinary cases during the last quarter, a increase on the figure of fifteen reported at the end of the previous quarter. Eleven of the

concluded cases resulted in a disciplinary hearing, the remaining eight investigations resulted in the following outcomes:-

- 2 investigation was found to have no case to answer
- 5 investigations resulted in counselling.
- 1 person resigned prior to the hearing.

At the end of September 2015 there were twenty four ongoing disciplinary cases, at varying stages of the disciplinary process, representing a slight decrease on the figure of twenty eight reported in the previous quarter.

A total of twenty nine safeguarding incidents were reported during the last quarter, representing an decrease on the figure of twenty six during quarter one. Eight of the cases involved Trust staff. Of these incidents none have progressed to a disciplinary hearing as yet.

The case from the previous quarterly workforce report (Q3) is due to proceed to a disciplinary hearing with further allegations to be put to the individual as a result of the investigation. There was one case outstanding from quarter one which is due to proceed to a disciplinary hearing on 16th October 2015.

Figure 16 provides a breakdown of all ongoing disciplinary cases by directorate.

Figure 16 Current Locality Disciplinary Case Numbers

Trust	Durham & Darlington	Tees	Forensic Services	North York	EFM	Medic Staff	Corp
24	7	6	1	8	2	0	1

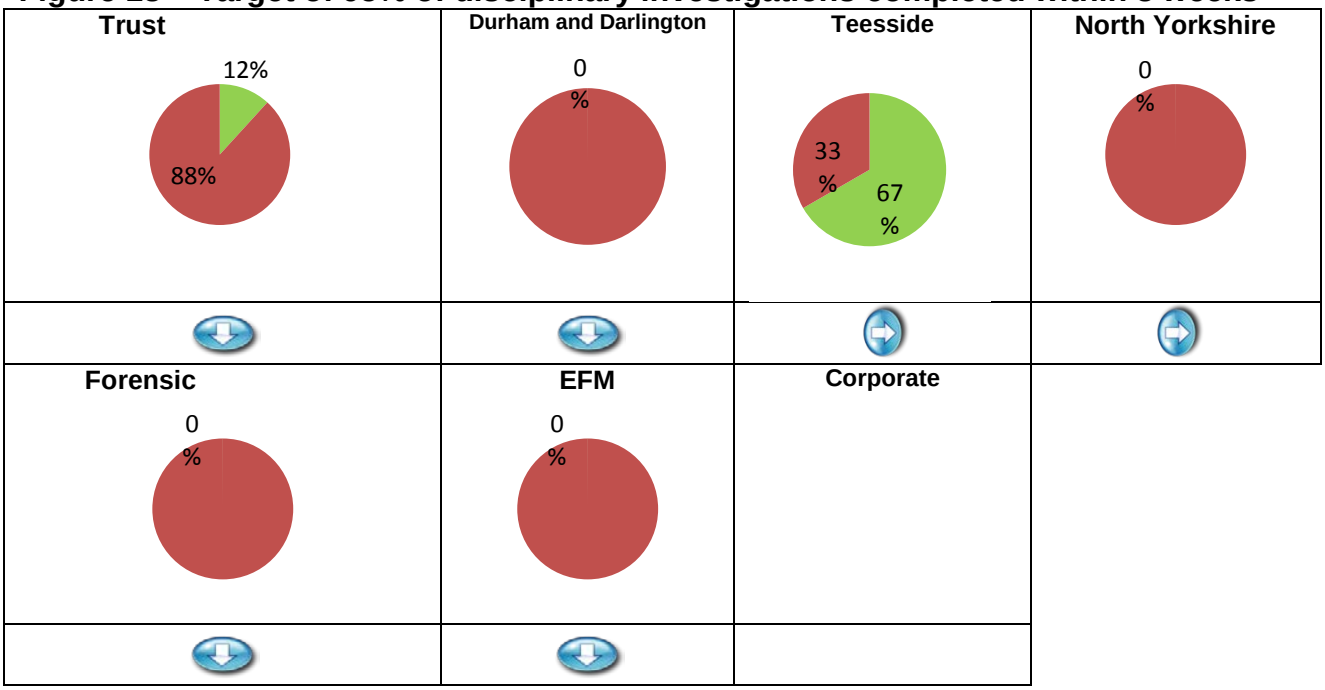
Figure 17 provides the outcomes of the eleven disciplinary hearings held during the last quarter. It can be seen that all of the disciplinary hearings held during the last quarter resulted in disciplinary action being taken.

Figure 17 Disciplinary Hearing Outcomes

Summary Dismissal	Alternative to Dismissal	Final Written Warning	Written Warning
1	0	3	7

Figure 18 provides information about performance against the target of completing 95% of disciplinary investigations within 8 weeks, excluding cases delayed due to sickness absence. A total of seventeen disciplinary investigations were concluded during the reporting period. The compliance rate of 12% represents a significant decrease on the figure of 67% reported for the previous quarter.

Figure 18 – Target of 95% of disciplinary investigations completed within 8 weeks



Grievances

There were a total of thirty eight concluded grievances within the last twelve months**.** The following table confirms the percentage of grievances concluded within three months of being raised and the average length of time taken to bring to a conclusion.

	Sept 15	Jun 15	Mar 15	Dec 14	Sep 14
% of grievances concluded within 3 months	79%	64%	58%	51%	58%
Average length of time in months taken to conclude grievance	2.1	2.6	2.9	3.1	2.9

- A total of 5 ongoing grievances were recorded at the end of September 2015 which is an decrease on the figure of 10 recorded at the end of June 2015.

Figure 19 shows the percentage of concluded grievances over the last twelve months that were completed within the three months target time. The time taken to conclude grievances has traditionally been less than the time taken to conclude disciplinary matters, and this remains the case.

Figure 19 Grievances Concluded Within 3 Months

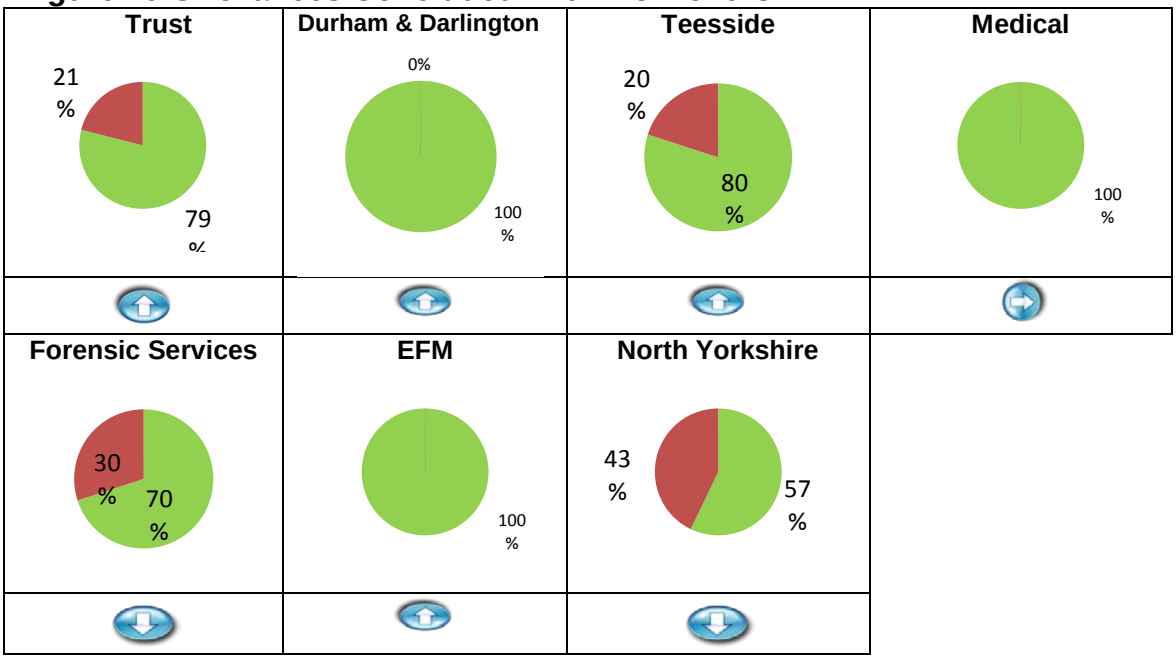
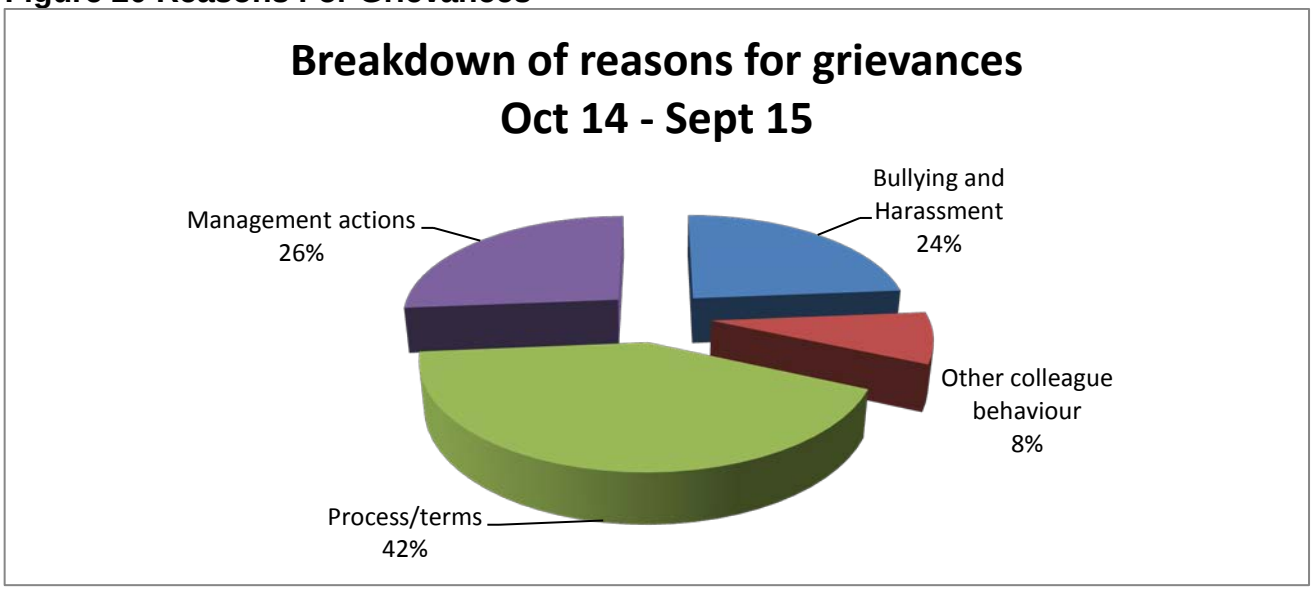


Figure 20 provides a breakdown of the reasons for grievances being lodged. It can be seen that grievances associated with bullying and harassment account for a 24% of all grievances within the Trust. Though the number of such grievances is less than 0.5% of the total Trust workforce it is important to monitor developments in this area and identify any significant trends that may require action on the part of the Trust. 42% of grievances relate to concerns raised relating to process or terms and conditions.

Figure 20 Reasons For Grievances



The following table highlights the outcome of grievances lodged during the 12 month reporting period.

Grievance Outcomes

Not upheld	Upheld/resolved	Partially upheld resolved	Mediation	Withdrawn before hearing
12	13	10	3	0

Bullying and Harassment

There is one bullying and harassment case under investigation at the end of September 2015. There have been no bullying and harassment cases that have resulted in a disciplinary process being invoked following the submission of a complaint during the last quarter.

9.0 Competence

Figure 21 provides information about the key performance indicator that 95% of staff should receive an annual appraisal resulting in a personal development plan. Forensic Services is the only locality showing an increase in compliance on the previous quarter and appear to be making good progress towards the target of 95%. The report shows performance as at end of August 2015.

Figure 21 Appraisal and PDP Completion Rates

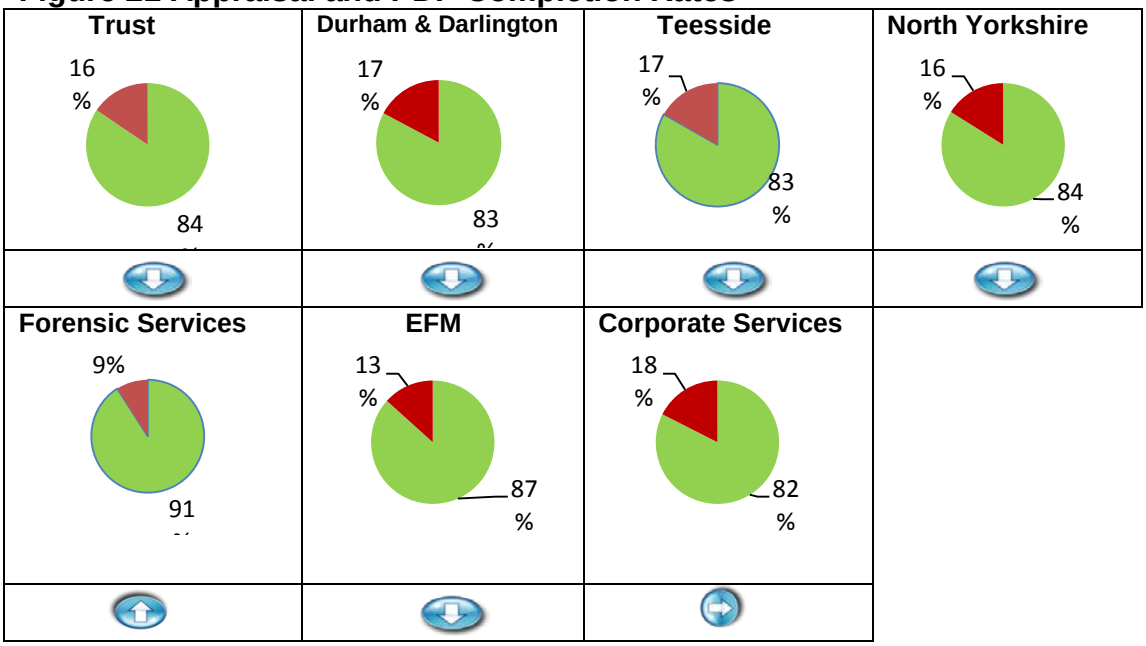
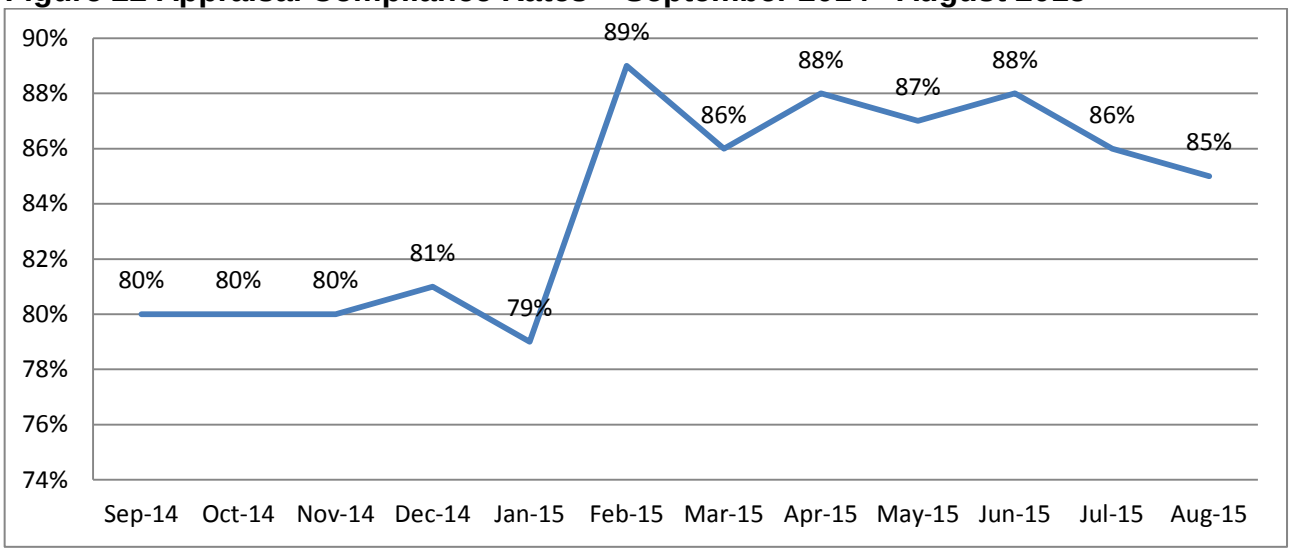


Figure 22 Appraisal Compliance Rates – September 2014 –August 2015



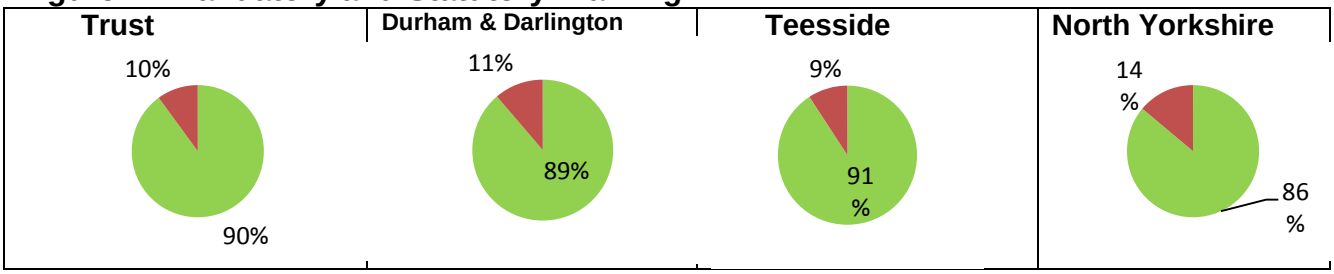
Monthly compliance reports are now available on the Integrated Information Centre (IIC) for managers to access and monitor compliance. Managers are able to update appraisal records directly within ESR Manager Self Service. The number of concerns being raised regarding the accuracy of the figures reported appears to have decreased since the roll out of the IIC.

Each locality has arrangements in place to proactively monitor and manage the HR related key performance indicators. A number of performance monitoring groups are in operation where team managers are required to provide updates on progress made against the performance indicators. Where deficiencies are identified action plans are developed and implemented. Directors of Operations and Heads of Service participate in a monthly Trust wide Performance Improvement group chaired by the Chief Operating Officer which includes providing updates on progress being made in relation to key HR related indicators.

Mandatory and Statutory Training

Figure 22 provides information about the percentage of staff undertaking core mandatory and statutory training at the end of August 2015 compared to the Trust target rate of 95%. All localities and services are reporting an increase in compliance compared with the previous reporting period. Estates and Facilities Management are reporting 95% compliance and Corporate Services reporting 94%.

Figure 22 Mandatory and Statutory Training



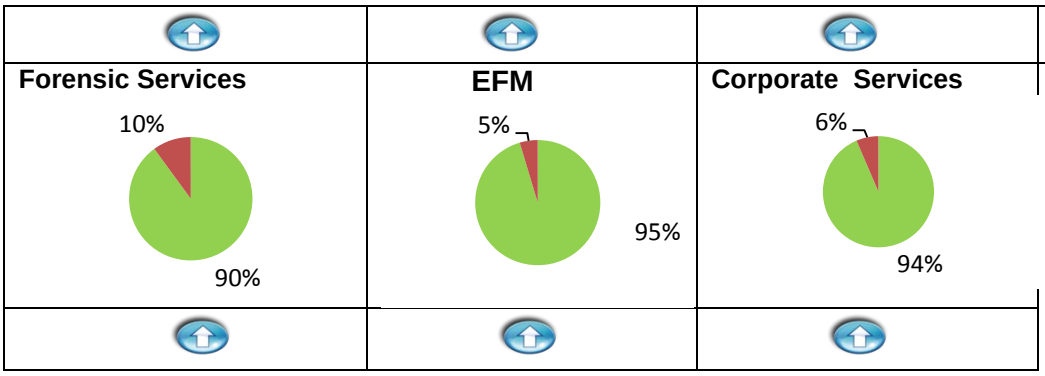
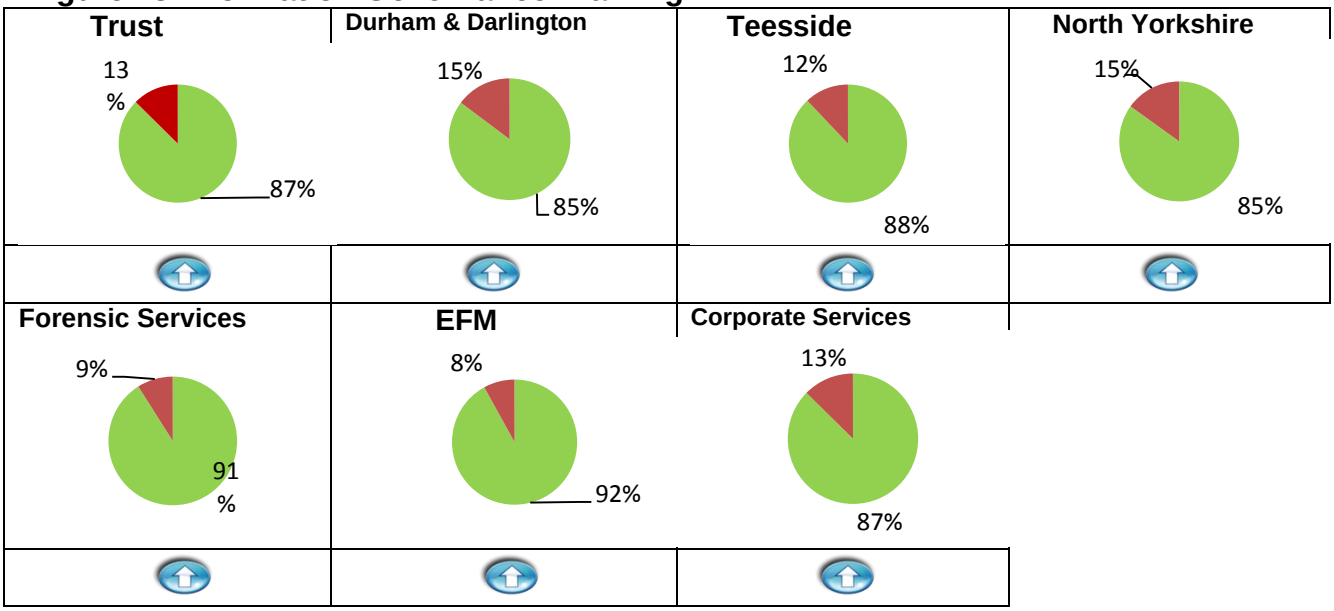


Figure 23 shows the compliance rate for Information Governance training as at the end of August 2015 against a target of 95%. Information Governance compliance is based on all staff turning red on 1st April 2015. 72% of staff completed the training within the first quarter of the reporting period.

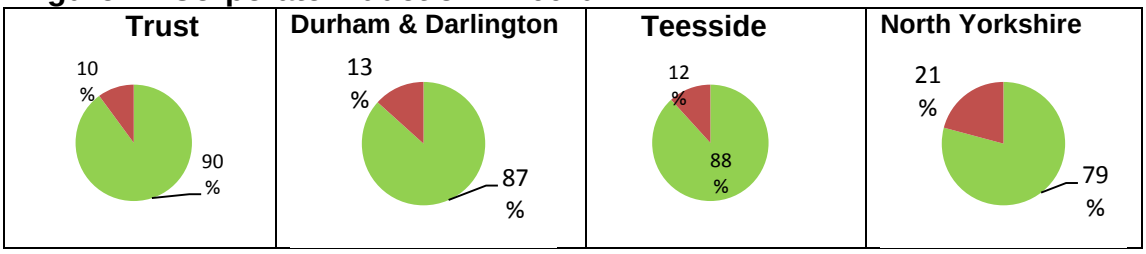
Figure 23 Information Governance Training



Induction

The 90% corporate induction compliance rate recorded for the last quarter in Figure 24 represents an increase on the figure of 85% reported at end of June 2015, however this remain below target. This was due to 10 members of staff failing to complete corporate induction within 2 months of commencement of employment during the reporting quarter. The compliance figure excludes bank workers whose compliance rate was 100%.

Figure 24 Corporate Induction – 100%



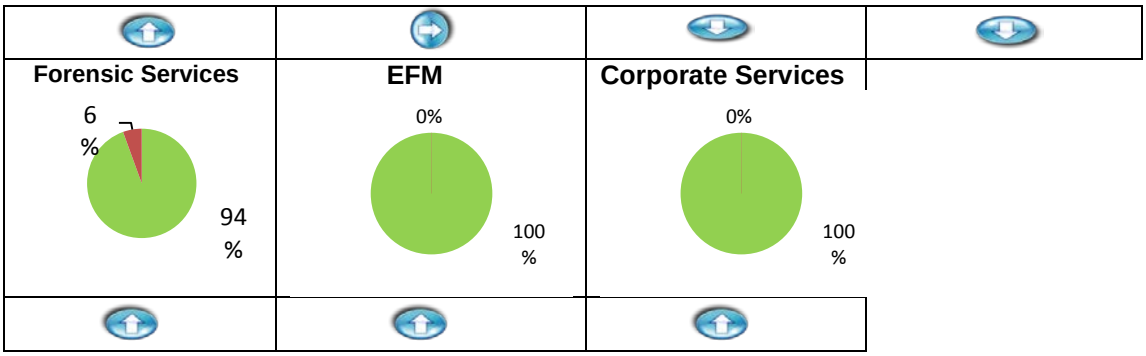
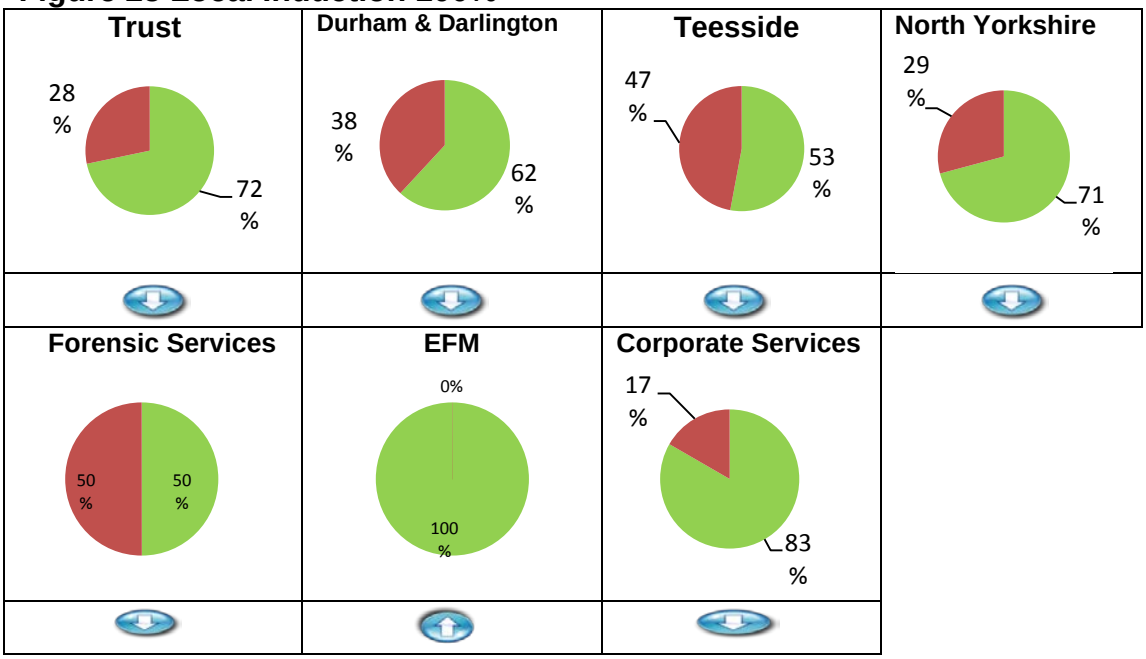


Figure 25 concerns the local induction compliance rate which decreased from 79% to 72% in the last quarter. A monthly report is sent out to Heads of Services highlighting those staff requiring local induction, along with a reminder in the middle of the month to confirm outstanding returns. Services are monitoring local induction compliance on a monthly basis through management meetings.

- The 28% non-compliance figure equates to 28 out of 99 staff failing to confirm completion of local induction within the 2 month timescale.
- The compliance figure excludes bank workers. The compliance rate for bank workers completing local induction is 100%

Figure 25 Local Induction 100%



10.0 Recruitment

- The key performance indicators below provide information about the time taken to recruit to vacancies.
- Percentage of band 1 – 5 vacancies recruited to within 13 weeks of advert being placed against a target of 75%.
- Percentage of band 6 – 9 vacancies recruit to within 15 weeks of advert being placed against a target of 75%
- Figures 26 and 27 show the percentage of staff recruited during the reporting period April to June 2015 compared to the performance indicators identified above.

There were 118 candidates recruited during the reporting period which is an increase on the previous quarter of 102.

There has been a decrease in the compliance against the target recruitment time for bands 1 – 5 from 52% to 29%. 95% of successful candidates were external applicants which is an increase on the figure of 88% during the previous quarter. The number of external candidates may have an impact on the length of time taken to recruit due to notice periods required to leave current posts.

- A total of 2 newly qualified staff nurses commenced employment during the reporting period.

The average length of time taken to recruit to bands 1 – 5 increased to 16 weeks for the reporting quarter.

Figure 26 Bands 1- 5 Recruitment Within 13 weeks

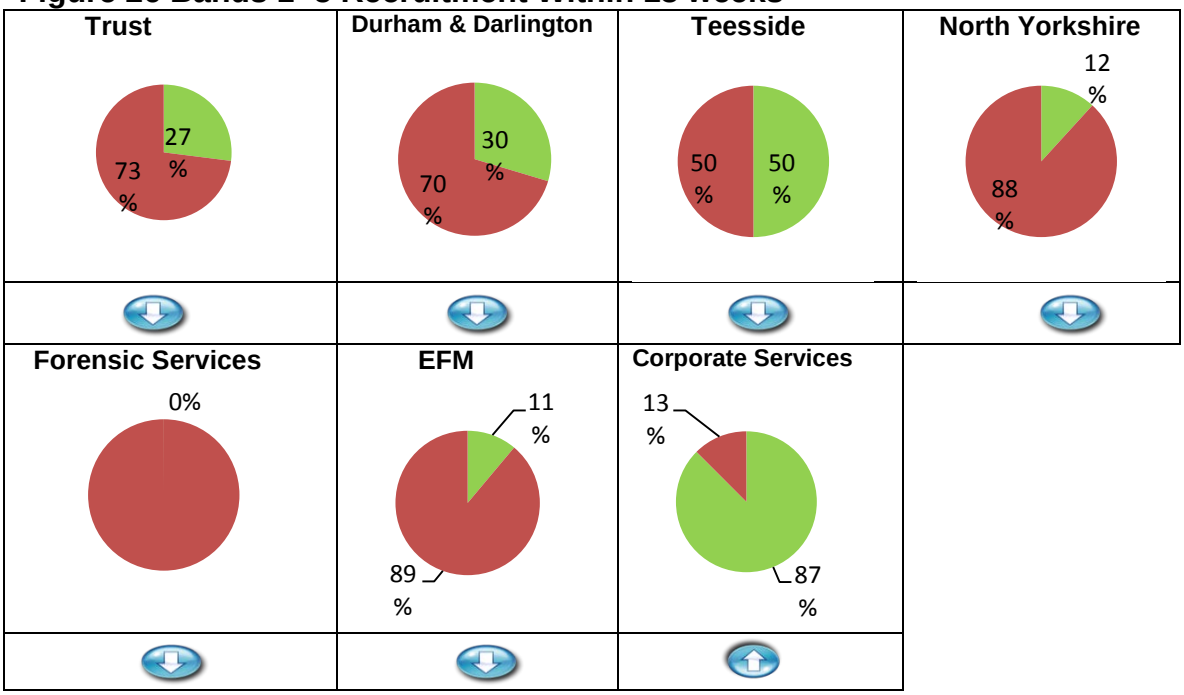
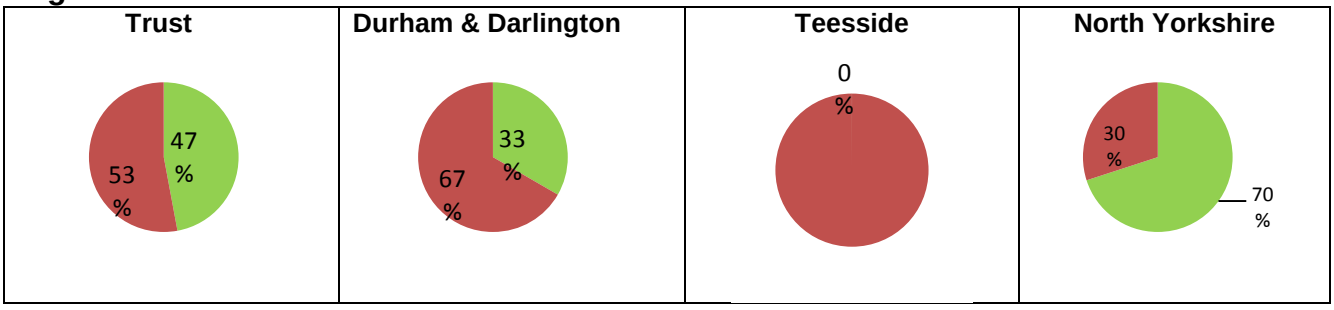
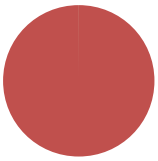
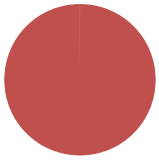


Figure 27 concerns the average length of time taken to recruit to bands 6 and above has increased to 17 weeks from 15 weeks during the last quarter. 100% of the successful candidates for band 6 and above were external applicants. This is an increase on the figure of 88% reported in the previous quarter.

Figure 27 Bands 6 - 9 Recruitment Within 15 weeks



Forensic 0% 	**EFM**	Corporate Services 0% 	

Analysis of recruitment episodes undertaken during the last quarter highlights the following:-

- average length of time taken for short-listing increased to **7 days from 4 days.**
- Average length of time taken for references to be received has decreased from 27 days to **21 days.**
- **40%** of references were received within **10 days** which is a decrease on the figure of 46% reported in the last quarter**.**
- Average length of time taken for Occupational Health clearance to be received has increased to **12 days** from 7 days.
- **72%** of Occupational Health clearances were received within 10 days representing an decrease on the figure of 87% reported during the last quarter.
- Average length of time taken for DBS clearance to be received reduced to **19 days** from 26 days.
- **66%** of DBS clearances were received within **21 days** representing an increase on the figure of 55% reported during the last quarter**.**
- The average length of time taken for pre-employment screening to be completed has increased to **41 days** from **39 days.**
- **28%** of pre-employment screening was completed within 28 days representing a decrease on the figure of 31% reported during the last quarter.

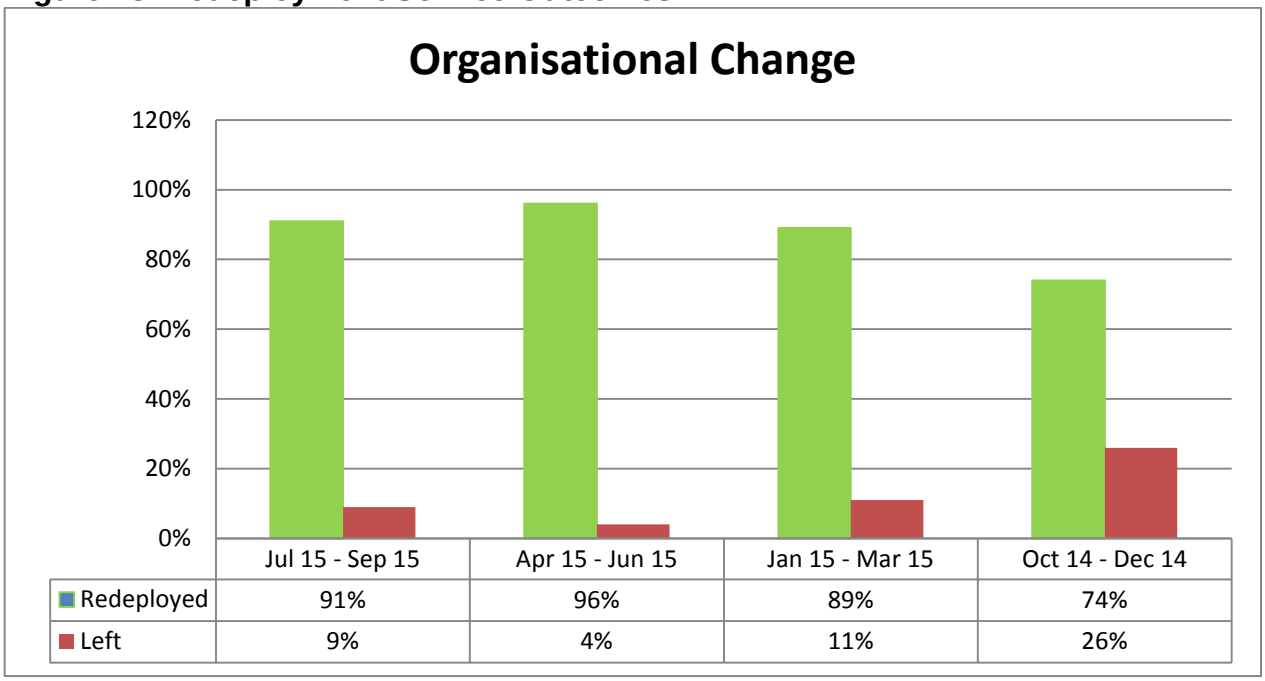
11.0 Redeployment Process

The redeployment process is the mechanism adopted within the Trust for searching for suitable alternative employment opportunities for staff finding themselves either displaced or at risk of being displaced from their post as a result of either Organisational Change or on due to medical incapacity.

The table below records the number of staff managed within the redeployment process since Octover 2014, who have either been successfully redeployed or have left the organisation. Figure 28 highlights the percentage of staff redeployed (green) compared to those leaving the organisation (red).

	Jul 15 – Sep 15	Apr 15 – Jun 15	Jan 15 – Mar 15	Oct 14 – Dec 14
Number of staff managed within process	11	49	52	34

Figure 28 Redeployment Service Outcomes



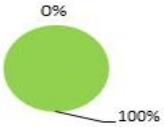
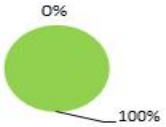
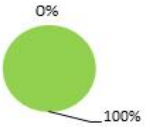
	Jul 15 - Sep 15	Apr 15 - Jun 15	Jan 15 - Mar 15	Oct 14 - Dec 14
Redeployed	91%	96%	89%	74%
Left	9%	4%	11%	26%

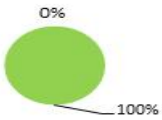
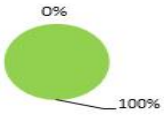
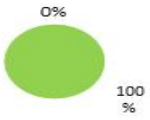
12.0 Professional Registration

The Trust target is that 100% of professional registered staff, required to have professional registration, do not allow their professional registration to lapse. Figure 30 below provides a breakdown of the position in respect of those staff whose registration was due to be renewed during the period July 2015 and September 2015.

A total of 836 staff were due to update their professional registration during the reporting period. **Two members of staff failed to renew their professional registration during the reporting period.** The lapses occurred within Durham and Darlington and Teesside. The compliance rate is **99.77%** A monthly report has been introduced to alert line managers when a member of staff is due to renew their professional registration and a policy of suspending those staff whose registration lapses, on zero pay, is in place. Where the registration is still showing as not updated the team liaise directly with the employee and the line manager to alert them. This intervention has drastically reduced the number of staff that failed to update their registration.

Figure 30 Professional Registration Renewals %

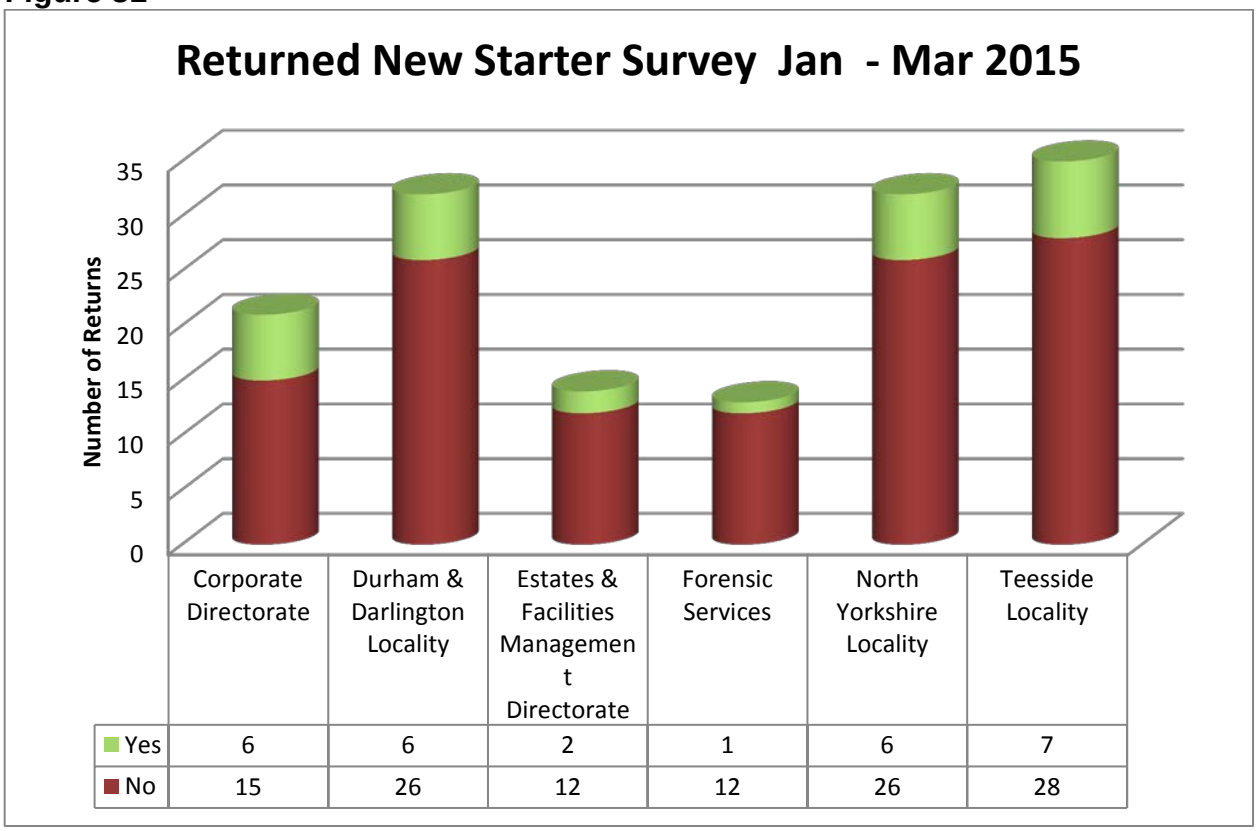
Trust	Durham & Darlington	Teesside
		
		

North Yorkshire	Forensic Services	Nursing& Governance
		

13.0 New Staff Survey

The Trust introduced a survey of new staff after they have been in post for six months. The survey was introduced in October 2013. The Trust was keen to capture the views of new staff to learn how to improve as an employer and as a provider of service. The graph at figure 31 highlights the return rate of questionnaires by Locality. The graph includes questionnaires sent to staff commencing employment between January and March 2015.

Figure 31

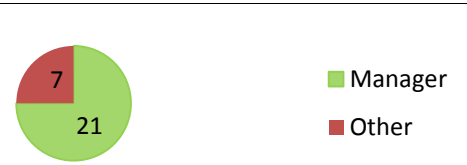
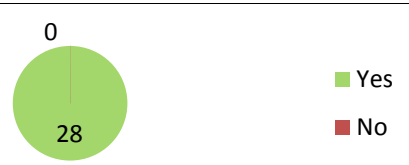
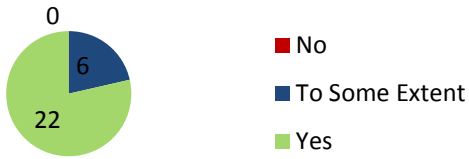
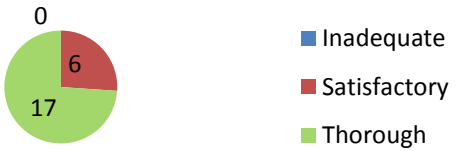


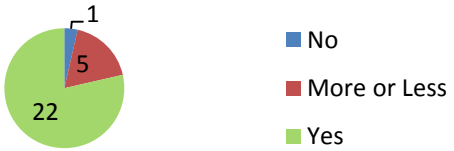
	Corporate Directorate	Durham & Darlington Locality	Estates & Facilities Management Directorate	Forensic Services	North Yorkshire Locality	Teesside Locality
Yes	6	6	2	1	6	7
No	15	26	12	12	26	28

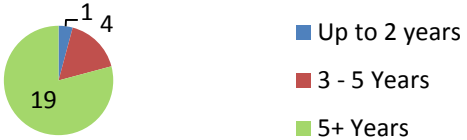
The table below highlights the return rate by month by locality over the last six months. It should be recognised that the number of new staff commencing employment each month can be as small as 1 or 2 which may also influence the return rate.

	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Oct – Mar
Trust	24%	20%	29%	18%	11%	28%	21%
Durham and Darlington	43%	30%	33%	25%	22%	9%	26%
EFM	0%	0%	40%	0%	0%	50%	18%
Forensic Services	9%	11%	33%	17%	0%	0%	11%
North Yorkshire	23%	8%	20%	25%	8%	27%	21%
Teesside	0%	50%	100%	11%	14%	33%	19%
Corporate	37%	33%	0%	0%	14%	50%	31%

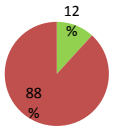
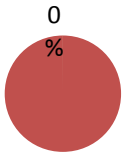
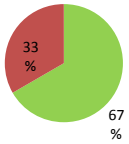
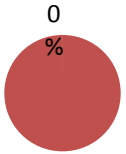
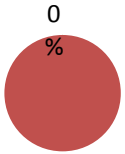
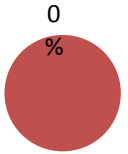
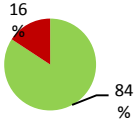
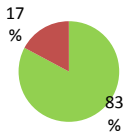
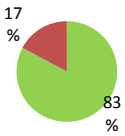
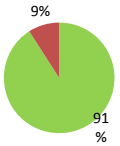
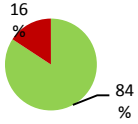
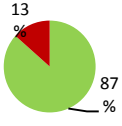
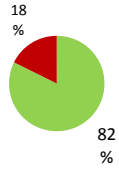
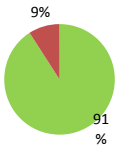
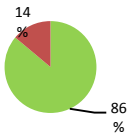
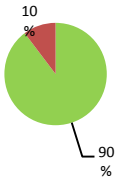
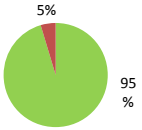
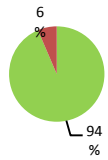
The following graphs highlight the responses received for those staff commencing employment between January 2015 – March 2015.

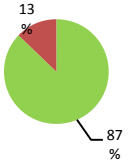
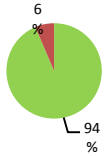
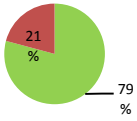
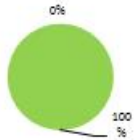
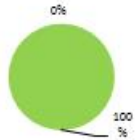
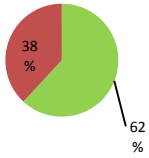
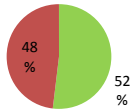
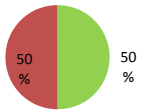
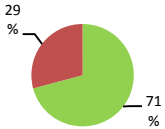
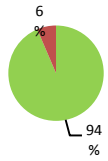
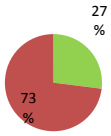
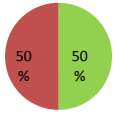
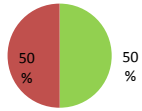
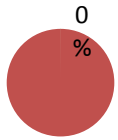
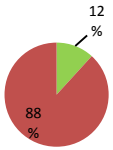
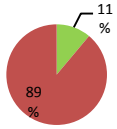
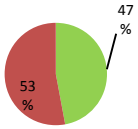
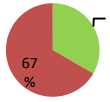
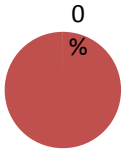
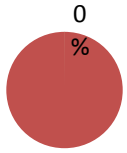
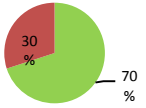
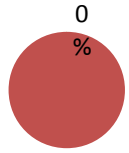
Q1	Before the first day of your work in the Trust were you given clear instructions on where to go and who to report to?		Q2	Were those instructions accurate?	
Q3	Did the Manager of the service personally meet you on your first day or a different member of staff?		Q4	Were you made to feel welcome by the person who met you?	
Q5	Were you made to feel welcome by other members of staff in the service?		Q6	Did your Manager spend time reviewing expectations and work requirements?	
Q7	Did your Manager complete the Local Induction Part1/orientation on your first day?		Q8	Were you assigned to a member of staff who was responsible for your learning?	
Q9	What was the training like (for example was adequate time, attention, detail etc shown by the person showing you the work of your new job)?		Q10	Do you feel that the person who trained /inducted you, knew the job well enough?	

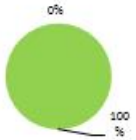
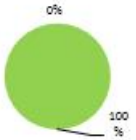
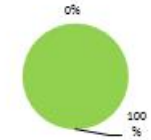
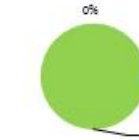
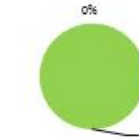
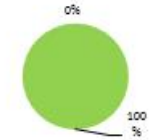
Q11	Did you complete your local induction within 8 weeks of commencing in post?		Q12	Do you feel as though you now know the job well enough to undertake the job with confidence and meet expectations?	
Q13	Do you know what the requirements for safety are?		Q14	Do you know what the requirements for quality are?	
Q15	Do you know what the requirements for patient confidentiality are?		Q 16	Does your Manager know and understand the requirements for your job?	
Q17	What suggestions do you have for improving the training/induction arrangements for new staff in your service?	More about processes for attendance/letters/courses I went to the trust induction on the first day in Middlesbrough but no information was provided to me as to where it was. Email confirmation would have been helpful. I think perhaps a 6 month probation period is too long, or at least having 4 weekly probationary assessments seems a bit overkill. However, I am not complaining about it and am happy to do this. Could some of the mandatory training be completed at induction? Could it be made clear which training courses are to be completed as I completed the wrong ICP training and had to do it twice and I think this may have been the case for the safeguarding adults. I think ESR has a lot of options for the same/similar course so perhaps a handy guide may be useful. I was happy with the initial meeting and subsequent training. All arrangements were suitable for the role. My first day was the regular staff induction at The Riverside. I thought that this really helped. Overall I was very satisfied. My only observation was that the first week which involved a lot of PARIS/computer system training was very rushed and it was very difficult to retain the information. Team is very good, but manager was not helpful. Gave me a scrap piece of paper telling me when I was to complete assessments. Had to wade self through work by taking own initiative and asking questions I was not confident about. Being able to shadow people for a week or so when you first start as this will give confidence knowing what work will be conducted and being able to ask questions on the job there and then while shadowing and the training giving little tasks of the work they have just shown. It was understandably difficult for me to be provided with training on my actual job as the person I replaced had left some weeks before but if I could of shadowed another member of admin staff just so that I was aware of procedure for the likes of IT, procurement (cardea), booking meeting rooms/travel/etc, it would have been extremely helpful. However, I must say that whenever I asked for information on any of the above tasks the response was immediate and thorough. I thought the induction process ran really smoothly and have no suggestions for improvement I am job share so only had a couple of hours in my first week with my job share (as well as a short hand over each week after that) but it felt quite a short time-frame to get up to speed and hit the ground. My other colleagues knew certain things but not others and then people were on annual leave too so I taught myself (with some written guides) a lot of things. Following my experience I am looking at expanding the information / guidance we can provide for new starters based on my experience, such as where to find files and folders, the types of enquiries that we may get and how to deal with them etc. I think it is good also to have a tour of the building we work in so we know our surroundings and what else is in the building. The induction process and the overall process of starting a new job were easy for me due to a very helpful team			

Q18	Would you recommend the service in which you work to anyone else to work in?		Q19	How likely is it that you will decide to continue working in the Trust?	
Q20	Have the Trust Values and associated Behaviours been explained to you?		Q21	Are you comfy with those Values and Behaviours?	
Q21	Do you have any suggestions for improvements that might reduce waste/and or improve quality within either the service you are employed within or, more broadly, within the Trust?	The trust needs to realign itself to children's services nationally rather than be stuck in the past. Cut backs on the paper work that is a paper exercise and not printing things off that are documented on PARIS. We send a large amount of letters to GP's that could be avoided by enabling email correspondence. "I think that there needs to be more support for new people to the Trust who have gained employment as a receptionist or ward clerk. It's quite different being a receptionist in say a Car Sales Showroom to being a receptionist on a Mental Health Out/In patient facility. Advice on how to respond and what to expect etc. I think it would be nice for admin staff who are interested in working on the bank, be given the opportunity to do volunteer work and enrol on the NVQ course. It's good for morale and then when you recruit you have a reliable member of staff. Having worked in a lot of different Trusts across the country I can say that this Trust appears to be the least wasteful and the most organised and conscientious. Its also by far the best in communication and care for staff wellbeing. I am a very happy employee! Paris- Medication section to be made available. Overall the Trust has exceeded my expectations. I do find, however, that it is hard to search for names and numbers pn the intranet and feel that this could be vastly improved. Team appears to have meetings about meetings and lot of wasted time. Feel undervalued at times as not allowed to make decisions without having a meeting. Rest of time are not allowed to be autonomous in decision making Being flexible regarding working bases and adding hot desk rooms so staff can work at multiple bases or given a laptop so different venues can be visited or even working at home will Reducing waste by turning off computers when not in use. The majority are on constantly even on rooms where they are seldom used. Even the screen being turned off saves money. In JCUH the new initiative was to turn off the screen and the computer off fully if leaving for a longer period of time. Also turning the lights off in rooms when no one is in the room. .Boost improvement, quality and staff morale. I am currently still observing practices and do not feel that I am able to comment at the moment on this issue . I am happy and confident to report to staff on the ward when I feel changes could be made to benefit patients and the service we provide. There are lots of meetings and as we grow as a Trust this means lots of travelling. As a part time worker this can take up a huge amount of time. I think there are benefits to face to face meetings and this is often needed. However I think we can also invest in and utilise technology better and do conference calls etc. This will reduce travel costs, improve time efficiency and productivity.			
Q22	How long would you envisage remaining in the employment of the Trust?		Q23	Is your contract permanent or fixed term?	

KEY PERFORMANCE INDICATOR SUMMARY

	Key Performance indicators	Target	Trust	Durham & Darlington	Teesside	Forensic	North York	EFM	Corp
1	Labour Turnover rate	8% - 12%	10.2%	10.4%	9.4%	9.1%	10.9%	7.5%	12.2%
2	Sickness Absence FYTD	4.5 %	4.5%	4.5%	4.8%	6.1%	4.3%	4.1%	2.4%
3	% of investigations concluded within 8 weeks	95%							
4	% of staff receiving an annual appraisal	95%							
5	% of staff compliant with mandatory and statutory training	95%							

	Key Performance indicators	Target	Trust	Durham & Darlington	Teesside	Forensic	North York	EFM	Corp
6	% of new starters attending corporate induction within 3 months of commencing employment	100%							
7	% of new starters confirmation of local induction checklist completed within 3 months of commencing employment	100%							
8	% of band 1 -5 recruited within 13 weeks	75%							
9	% of band 6 – 9 recruited within 15 weeks	75%							

10	% of professional registered staff with a current professional registration against a target of 100%	100%							

Medical Workforce Report (2015 Quarter 2)

MEDICAL DIRECTORATE

This report provides information about the medical workforce during the second quarter, July to September 2015.

The report will be divided into the following sections:

- Section 1 - Medical staffing profile
- Section 2 - Medical staffing monitoring profile
- Section 3 - Vacancies
- Section 4 - Sickness
- Section 5 - Appraisals & revalidation
- Section 6 - Turnover
- Section 7 - Mind the gap payments
- Section 8 - Medical education overview

Section 1: Medical Staffing Profile

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

Table 1	D&D	Tees	N Yorks	Forensic	Overall Total
Permanent	104	85	67	33	289
Trust Locums	4	7	7		18
Agency Locums	2	2	7	2	13
Flex Retirement	5	1	3		9
Career Break	1	1		1	3
Honorary	2		1	1	4
Total	118	96	85	37	**336**

Table 1 shows that 36% of our permanent workforce is in the D&D locality. North Yorkshire has the most agency locums (7).

The table identifies that the permanent workforce make up 86% of the medical workforce. This compares comparably with the percentage in 2013.

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

Consultant Psychiatrists

Table 2	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Permanent	55	32	26	11	11	8	143
Trust Locums	1		3				4
Agency Locums	3		2		1	1	7
Flex Retirement	4	4		1			9
Vacant not cov'd	1	4	1		1		7
Career Break	1					1	2
Honorary	2	1			1		4
Total	67	41	32	12	14	10	**176**

Table 2 shows the number of consultants currently working within the Trust defined by specialty. The overall number of permanent staff has slightly increased. Please note that out of the 7 agency doctors, 5 are covering vacant posts and 2 are covering maternity leave.

The consultant workforce in AMH is of concern given 18% of its workforce is not permanent and may pose a risk in the future. Figures from 2014 show the same ratio of permanent consultants and locum consultants.

SAS Doctors

Table 3	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Permanent	13	6	12	1	3	3	38
Trust Locums	3		2		1		6
Agency Locums		1	2				3
Flex Retirement							
Vacant not cov'd		1				1	2
Career Break			1				1
Honorary							
Total	16	8	17	1	4	4	**50**

Table 3 shows the number of SAS grade doctors currently working within the Trust defined by specialty. This shows the position is largely unchanged from the last quarter.

Junior Doctors

Table 4	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Current	59	11	24	6	6	1	107
Vacancies not covered	7	2	2	1	1		13
Trust Locums	6		3				9
Agency Locums	2		1				3
Total number of posts	74	13	30	7	7	1	**132**

Table 4 shows all Trust junior doctor training posts. This has changed slightly since the last quarter as the junior doctors rotated in August. There was a reduced number on the training schemes (both CT and GP). 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 24 vacancies that are either filled by locums or that remain empty.

You will note that the Trust has 9 Trust doctor posts compared to 3 in 2013. This is quite unique and is as a consequence of the Trust doctor initiative whereby the Trust advertised opportunities for Trust doctors, mostly equivalent to the level of foundation one or two, to work and receive a tailored development programme. The programme was developed to make the doctor better equipped to be succesful on their application for core training. The Trust, together with a neighbouring Trust, recently recruited a number of Trust doctors from Budapest. These should be ready to commence in February 2016.

Table 5	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Foundation Yr 1	8		3				11
Foundation Yr 2	7		3		1		11
CT 1-3	25	5	9	5	2		46
ST 4-6	9	6	5	1	3	1	25
GP Registrars	10		4				14
Total	59	11	24	6	6	1	**107**

Table 5 shows the breakdown of junior doctors that are currently in post in the Trust. Of particular concern is the low number of higher trainees (ST 4-6) in specialties where we struggle to attract sufficient numbers of quality consultant applicants. This pattern will unfortunately continue until we are able to fill all of the core training posts in both regions.

On a more positive note, we continue to do all we can to support core trainees in passing their written and clincial papers. We have introduced the independent assessment of clincial skills (IACS), and this is now held twice yearly. A structured day long CASC programme was lauched last year and we continue to encourage opportunitist clincial skills training with trained supervisors.

In December Dr Peter Horn ran the day long CASC programme and 17 doctors attended. 14 of those went on to sit the CASC examination in January 2015 and of the 14, 10 candidates passed the exam giving a 71% pass rate, comparing very favourably with previous groups. There are obviously other contributing factors to these results but the immediate feedback from the event was very positive.

Section 2: Medical Staffing Monitoring Profile

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

Consultants by Age & Gender

	D&D		Tees		NY		Forensic		Total	
Table 1	Male	Female	Male	Female	Male	Female	Male	Female	**M**	**F**
30 – 34	1	2		2		1	1		**2**	**5**
35 – 39	4	7	11	4	3	3	3	3	**21**	**17**
40 – 44	7	6	3	4	6	2	3	2	**19**	**14**
45 – 49	7	3	4	2	8	5	5	1	**24**	**11**
50 – 54	6	8	4	2	2	2	2		**14**	**12**
55 – 59	4	3	1	3	3		1		**9**	**6**
60 – 64	2	1	2		3				**7**	**1**
65 – 69										
70+										
Total	**31**	**30**	**25**	**17**	**25**	**13**	**15**	**6**	**96**	**66**

Table 1 shows the number of male and female consultants categorised by age profile in each locality. The data includes all staff (eg permanent, locum, flexible retiree – except agency locums).

The majority of our consultant workforce is aged between 35 and 49 (65%), and the modal average of 35-39 age group remains the same. The male and female split in Durham and Darlington is still fairly equal which is not replicated in the other localities. Overall, there is a 59/41% male/female split respectively (females rising by 1% from last quarter).

Figures from the GMC are showing an increase in females graduating – in 2011, 53% of those gaining GMC registration were female. In addition, the number of females on the register is expected to exceed the number of males by 2017 (GMC, 2012). This suggests that the male to female ratio may even out in the Trust over the next few years.

Consultants by Age & Gender in Specialties

Table 2	AMH		CYPS		MHSOP		LD		Forensic MH		Forensic LD		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	**M**	**F**
30 – 34		2		2	1	1			1				**2**	**5**
35 – 39	9	6	2	4	3	2	4	2	2	1	1	2	**21**	**17**
40 – 44	8	7	4	2	3	2	1	1	2		1	2	**19**	**14**
45 – 49	9	3	5	4	4	3	1		4	1	1		**24**	**11**
50 – 54	8	1	3	6	1	4		1	1		1		**14**	**12**
55 – 59	3	2	1	2	3	1	1	1			1		**9**	**6**
60 – 64	4	1	2		1								**7**	**1**
65 – 69														
70+														
Total	41	22	17	20	16	13	7	5	10	2	5	4	**96**	**66**

Table 2 shows the number of male and female consultants in various age brackets defined by specialty. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. Interestingly, Forensic Services has a relatively young workforce with only 3 out of 22 doctors over the age of 50, while the other specialties together make up 31% of the consultant workforce over the age of 50.

In addition, the lack of a female workforce in Adult Mental Health and Forensic Mental Health is quite evident from the data.

SAS Doctors by Age & Gender

Table 3	D&D		Tees		NY		Forensic		Total	
	Male	Female	Male	Female	Male	Female	Male	Female	**M**	**F**
30 – 34							1		**1**	
35 – 39	3					3			**3**	**3**
40 – 44	1	2	1	2			1	1	**3**	**5**
45 – 49	3	4		4	1	1	1	1	**5**	**10**
50 – 54	1	2	2	1		1	1		**4**	**4**
55 – 59		1	1	1		1			**1**	**3**
60 – 64				1						**1**
65 – 69										
70+	1								**1**	
Total	**9**	**9**	**4**	**9**	**1**	**6**	**4**	**2**	**18**	**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. In comparison to the consultant workforce, there is a 41/59% split in favour of females (2% increase/decrease in males/females since last quarter), with noticably few males (1) in the North Yorkshire locality. In addition, the average workforce age is slightly higher (45-49), with slightly over a third (32%) being over the age of 50. It is also worth noting that our Teesside locality has a high proportion of its workforce in the over 50 category (46%).

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									1				**1**	
35 – 39	3	1		1		1							**3**	**3**
40 – 44		2		1	2	1			1			1	**3**	**5**
45 – 49	2	3		2	2	4				1	1		**5**	**10**
50 – 54	1	2		1	2	1					1		**4**	**4**
55 – 59	1			1		1		1					**1**	**3**
60 – 64		1												**1**
65 – 69														
70+					1								**1**	
Total	7	9		6	7	8		1	2	1	2	1	**18**	**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 all doctors are female.

Ethnic Origin

Consultants Table 5	D&D		Tees		NY		Forensic		Total	
	Male	Female	Male	Female	Male	Female	Male	Female	**M**	**F**
White British	10	19	8	10	13	10	8	2	**39**	**41**
White Irish	2	1							**2**	**1**
White European	2	1	2	1	3				**7**	**2**
White Polish							1		**1**	
White Other		1	1	1					**1**	**2**
Asian British – Indian	12	5	10	1	4	1	2	4	**29**	**11**
Asian British–Pakistani					1		2		**3**	
Asian British–Bangladesh					1				**1**	
Asian British–Other	1		1	1					**2**	**1**
Black British–African		1		1	2				**2**	**2**
Black British - Nigerian	1			1					**1**	**1**
Black British–Other	1		1				1		**3**	
Mix White/Black–African	1								**1**	
Mixed – Other			1				1		**2**	
Chinese		1								**1**
Other	1	1		1	1	1			**2**	**3**
Not Stated						1				**1**

Table 5 shows the number of male and female consultants in ethnic origin categories defined by locality. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums.

The table shows that just under half of the consultant workforce are 'White British' (80 White British and 82 non-White British).

When considering BAME consultants, 96 are from the EU while 66 are from Asia, Africa or elsewhere (59/41% respectively). Interestingly, the male/female split between the EU area and BAME areas is quite distinct – 53% of the EU workforce are male and 47% are female; in BAME areas, 70% of the workforce are male compared to 30% female. North Yorkshire have twice as many EU consultants as BAME.

SAS Doctors

Table 6	**D&D**		**Tees**		**NY**		**Forensic**		**Total**	
	Male	Female	Male	Female	Male	Female	Male	Female	**M**	**F**
White British	3	4		3		3	1		**4**	**10**
White European										
White Other	2	1		1				1	**2**	**3**
Asian British–Indian		2	3	4	1				**4**	**6**
Asian British–Pakistani	1					1	1		**2**	**1**
Asian British- Banglaesh	1								**1**	
Asian British–Other						1		1		**2**
Black British–African		1					1		**1**	**1**
Black British-Nigerian	1								**1**	
Black British			1						**1**	
Mix White/Black African							1		**1**	
Vietnamese				1						**1**
Other	1	1				1			**1**	**2**

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 32% of the SAS workforce are 'White British' (14 are White British and 30 (68%) are non-White British). When considering BAME SAS doctors, 19 are from the EU and 25 are from Asia and Africa or elsewhere (43/57% respectively). In contrast to consultants, the male/female split in BAME areas is (48/52% respectively) whereas the EU workforce is highly biased towards females (32% males/68% females).

Full Time / Part Time

Table 7

Consultant										
	D&D		**Tees**		**NY**		**Forensic**		**Total**	
	Male	Female	Male	Female	Male	Female	Male	Female	M	F
Full Time	23	16	25	12	16	6	13	6	**77**	**40**
Part Time	8	14		5	9	7	2		**19**	**26**
Specialty Doctors										
Full Time	8	5	4	3	1	2	3	1	**16**	**11**
Part Time	1	4		6		4	1	1	**2**	**15**

Table 7 shows the number of male and female consultants / SAS doctors who are currently working full or part time defined by locality. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. This shows that overall, almost half (44%) of the career grade

workforce are full time males with just under a quarter (24%) of females in full time positions. In addition, only 10% of males and 20% of females are working part time. The number of part time workers could increase over the next few years due to the introduction of flexible training options open to all junior doctors.

Table 8

Consultant														
	AMH		**CYPS**		**MHSOP**		**LD**		**Forensic MH**		**Forensic LD**		**Total**	
	M	F	M	F	M	F	M	F	M	F	M	F	**M**	**F**
Full Time	36	15	8	8	15	9	5	2	9	2	4	4	**77**	**40**
Part Time	5	7	9	12	1	4	2	3	1		1		**19**	**26**
Specialty Doctors														
Full Time	6	4		3	7	3			2	2	1		**16**	**11**
Part Time	1	5		3		5		1			1	1	**2**	**15**

Table 8 shows the number of male and female consultants / SAS doctors who are currently working full or part time defined by specialty. This includes all types of staff, eg permanent, locum, flexible retiree – except agency locums. Of interest is the high numbers of part time staff in CYPS (56% part time compared to 44% full time).

Section 3: Vacancies

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

Table 1	**D&D**	**Tees**	**NY**	**Forensic**	**Total**
Consultant	5	5	4	1	15
SAS		1		1	2

Table 1 above shows the current vacancies in each directorate. Interestingly, the number of SAS vacancies has decreased from 7 to 2 from last quarter.

Table 2	**AMH**	**CYPS**	**MHSOP**	**LD**	**FMH**	**FLD**	**Total**
Consultant	6	4	4		1		15
SAS		1				1	2

Table 2 above shows the current vacancies in each specialty. LD remains with no vacant positions.

Vacancy Breakdown

Table 3

Vacancies	**Locum in place**	**Times Advertised**	**Date of Advert**	**Date of Interview**	**Appt made**	**Start date**
Consultant in AMH (Inpatient / Crisis) RPH	Agency Locum	0				
Consultant in AMH (PICU) RPH	No	0				
Consultant in Liaison North Tees	Subs Cons	0				
Consultant in CYPS The Ridings, Redcar	No	1	07/03/15	29/04/15	No	
Consultant in CYPS Viscount House, Stockton	No	0				
Senior Specialty Doctor in CYPS (specialist in Paediatrics) Viscount House, Stockton	No	1	22/08/15	30/09/15	Yes	Jan 2016
Consultant in AMH (Community Eating Disorders) Imperial House	Agency Locum	0				

Vacancies	Locum in place	Times Advertised	Date of Advert	Date of Interview	Appt made	Start date
Consultant in AMH (Substance Misuse) LRH	No	2	~~20/06/15~~ 22/08/15	~~04/08/15~~ 27/10/15		
Consultant in CYPS Acley Centre, South Durham	Subs Cons	1	28/08/15	28/09/15	Yes	Feb 2016
Consultant in MHSOP Easington	Trust Locum	3		18/03/15	No	
Consultant in MHSOP (Liaison) LRH	No	3		18/03/15	No	
Specialty Doctor in AMH Crisis, West Park	Subs SAS	0	Internal		Yes	05/08/15
Specialty Doctor in AMH PICU, Rehab, West Park	Trust Locum	0	Internal		Yes	05/08/15
Consultant in AMH (Working Age Psychiatry) Ellis Ct, Sbr	Agency Locum	2		27/04/15	No	
Consultant in MHSOP Cross Lane Hospital / Malton	Trust Locum	1		30/07/15		
Consultant in MHSOP Whitby	Acting Cons	0				
Consultant in CYPS (Tier 4) West Lane Hospital	No	2		29/04/15	No	
Consultant in Forensic (Forensic Mental Health), RPH	No	1			No	
Specialty Doctor in Forensic (Forensic LD), RPH	No	1		27/07/15	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 (July to September 2015). Within this period 8 posts were advertised and recruitment has been partially successful.

Table 4

Vacancies advertised	Times advertised	No of candidates applied	No of candidates shortlisted	Appointment made
Senior Specialty Doctor in CYPS (Paeds) Viscount House	1	1	1	Yes
Consultant in AMH (Substance Misuse) Lanchester Road Hospital	1	0	0	No
Consultant in CYPS Acley Centre, South Durham	1	2	2	Yes
Specialty Doctor in AMH/Crisis West Park Hospital	0	1	1	Yes
Specialty Doctor in PICU/Rehab West Park Hospital	0	1	1	Yes
Consultant in MHSOP Cross Lane Hospital	1	0	0	No
Consultant in Forensic Psychiatry Forensic Mental Health, Roseberry Park	1	0	0	No
Specialty Doctor in Forensic Psychiatry Forensic LD, Roseberry Park	1	1	1	No

Table 4 shows a 50% fill rate on the jobs advertised in this period.

Section 4: Sickness

Doctors on Long Term Sick Leave by Locality

Figure 1

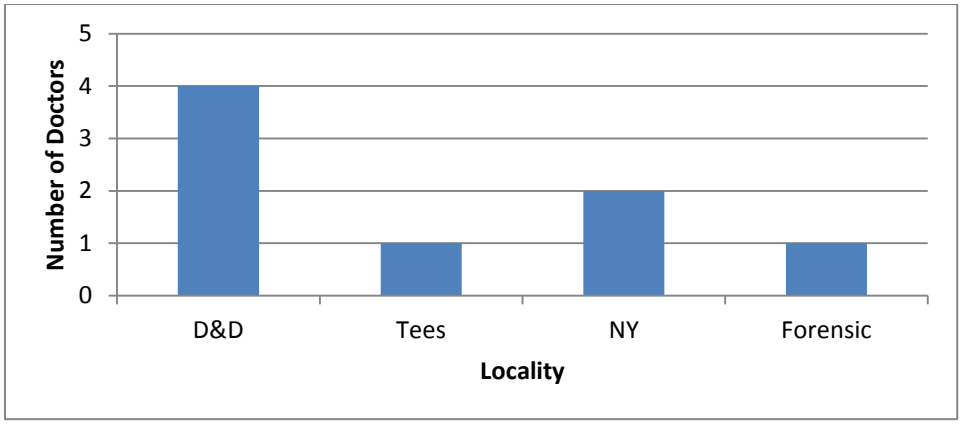


Figure 1 shows the number of doctors on long term sick (includes 5 consultants, 3 SAS). Three out of the eight doctors continued on long term sick from last quarter.

Reasons for Sickness Absence

Figure 2

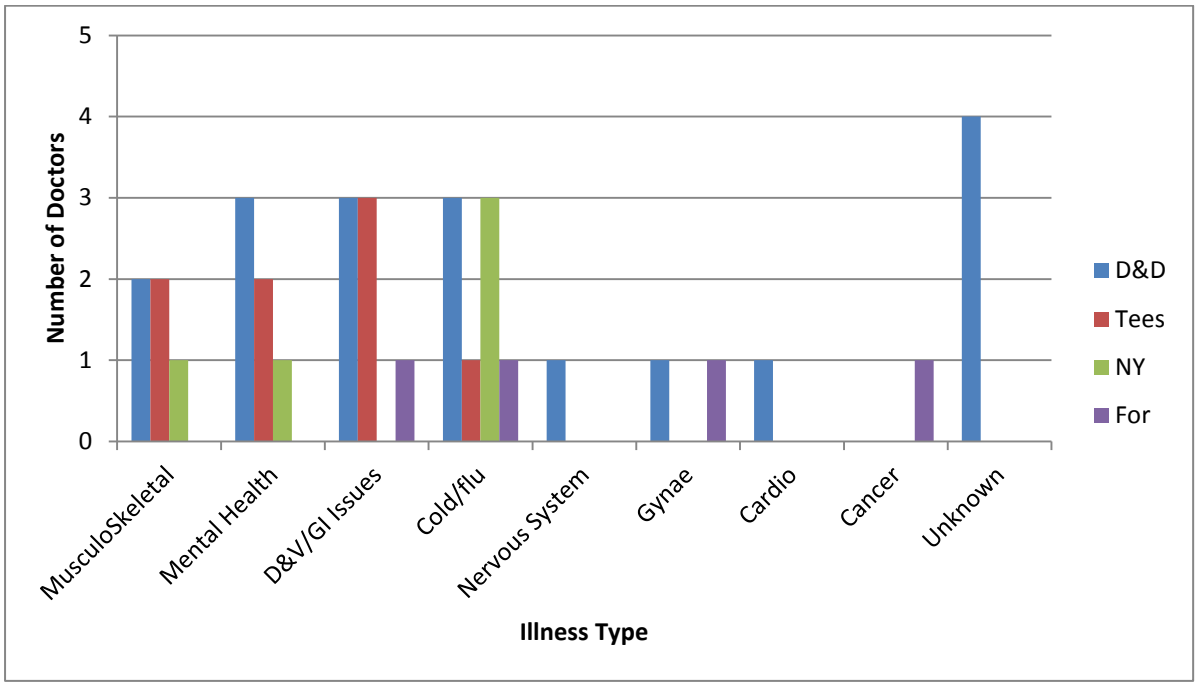


Figure 2 shows the reasons for sickness absence (including long term sickness) during the period July to September 2015. This includes all grades of doctor except agency locums. Interestingly, there are a high number of 'diarrhoea and vomiting' episodes in Durham & Darlington and Teesside, as well as a decrease in mental health issues (8 last quarter), musculoskeletal problems (8 last quarter), cold and flu symptoms (10 last quarter). Overall, 611 days were lost due to sickness (122 days more than last quarter) out of which 92 were for short term illnesses and 514 were for long term illnesses.

Section 5: Appraisals and Revalidation

Consultants

Table 1	D&D	Tees	NY	For	Total
Appraisals Due	19	10	12	3	44
Appraisals Actual	18	9	12	3	42

Table 1 shows the number of consultant appraisals that were due between 1st July 2015 and 30th September 2015 and how many were actually completed. The total number is broken down into locality.

Table 2	D&D	Tees	NY	For	Total
Revalidation Due	2	3	2	2	9
Revalidation Actual	2	1	1	2	6

Table 2 shows the number of consultants who were due revalidation between 1st July 2015 and 30th September 2015 and those who were successfully revalidated. The numbers are broken down into locality.

SAS

Table 3	D&D	Tees	NY	For	Total
Appraisals Due	1	0	3	1	5
Appraisals Actual	1	0	2	1	4

Table 3 shows the number of SAS doctor appraisals that were due between 1st July 2015 and 30th September 2015 and how many were actually completed. The total number is broken down into locality.

Table 4	D&D	Tees	NY	For	Total
Revalidation Due	2	1	0	1	4
Revalidation Actual	2	1	0	1	4

Table 4 shows the number of SAS doctors who were due revalidation between 1st July 2015 and 30th September 2015 2015 and those who were successfully revalidated. The numbers are broken down into locality.

Trust Doctor

Table 5	D&D	Tees	NY	For	Total
Appraisals Due	0	1	2	0	3
Appraisals Actual	0	1	2	0	3

Table 3 shows the number of Trust doctor appraisals that were due between 1st July 2015 and 30th September 2015 and how many were actually completed. The total number is broken down into locality.

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

Table 4 shows the number of Trust doctors who were due revalidation between 1st July 2015 and 30th September 2015 and those who were successfully revalidated. The numbers are broken down into locality.

Section 6: Turnover

This section considers the number of doctors who have commenced in the Trust between 1st June 2015 and 30th June 2015. It also highlights the number of doctors leaving the Trust and their leaver destination.

New Starters vs Leavers by Locality

Table 1	D&D	Tees	NY	Forensic	Total
New Starters		2	1		3
Leavers	1	1	3	1	6

Table 1 highlights the number of new starters against the number of leavers. Again, this includes all types of staff except agency locums. This shows there has been considerably more activity to last quarter (4 starters, 1 leaver).

New Starters vs Leavers by Specialty

Table 2	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
New Starters	1	1	1				3
Leavers	2	1	2			1	6

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	1	1
Leavers		4	2

Table 3 shows the number of new starters against the number of leavers defined by grade. This includes all types of staff, eg permanent, locum, trust doctors – except agency locums.

Leaver Destination by Locality

Table 4	D&D	Tees	NY	Forensic	Total
Flexible Retirement					
Fully Retired					
Moved Abroad					
Needed to Relocate				1	1
Joined NHS Trust					
Joined Train Scheme	1	1	3		5

Table 4 shows the destination of doctors after leaving the Trust, defined by locality. This includes all types of staff, eg permanent, locum, trust doctors – except agency locums. The age of the leaver in Forensics is 44 and is moving to be with husband who has a permanent position elsewhere in the country. The other 5 are between 31 and 50 years old and are joining training schemes in this area or elsewhere in the country.

Leaver Destination by Specialty

Table 5	AMH	CYPS	MHSOP	LD	FMH	FLD	Total
Flexible Retirement							
Fully Retired							
Moved Abroad							
Needed to Relocate						1	1
Other NHS Trust							
Joined Training Scheme	2	1	2				5

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

Leaver Destination by Grade

Table 6	Consultants	SAS	Trust Doctors
Flexible Retirement			
Fully Retired			
Moved Abroad			
Needed to Relocate		1	
Other NHS Trust			
Joined Training Scheme		3	2

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

Section 7: Mind the Gap Payments

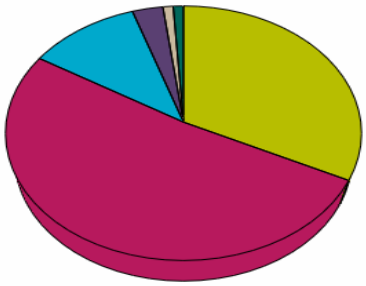
This section includes the number of extra PA payments that are being made within 'Mind the Gap', eg for providing cover during sickness or vacancies. It is broken down into locality and specialty.

Table 1	AMH	CYPS	MHOSP	LD	FMH	FLD	Total
D&D	9	4	0.5	1			14.5
Teesside	6	13		2			21
NY	3.5	4	7				14.5
Forensic					15	11	26
Total	18.5	21	7.5	3	15	11	**76**

Table 1 shows the number of additional PAs under Mind the Gap. This shows that additional PAs in AMH have increased from last quarter, as have Forensic Services. This is most likely due to sickness and vacancies in those areas.

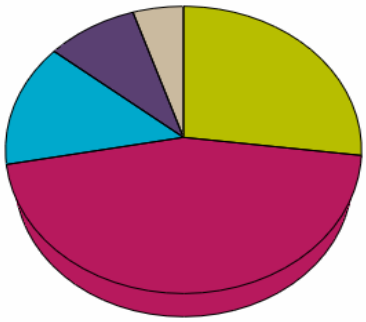
Trust Wide

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



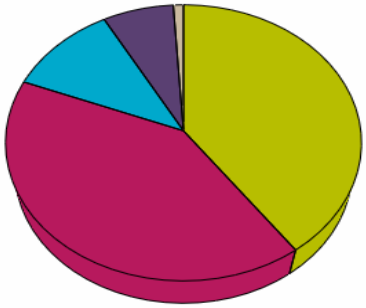
	Base	2598	
	Extremely likely *	838	32%
	Likely *	1324	51%
	Neither likely nor unlikely	293	11%
	Unlikely	88	3%
	Extremely unlikely	37	1%
	Don't know	18	1%

2 - How likely are you to recommend this organisation to friends and family as a place to work?



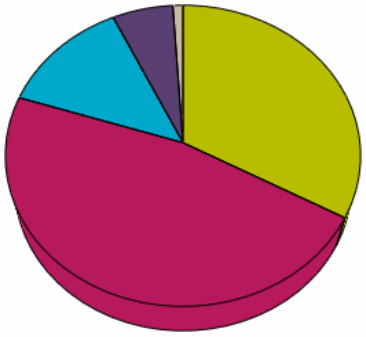
	Base	2600	
	Extremely likely *	703	27%
	Likely *	1179	45%
	Neither likely nor unlikely	367	14%
	Unlikely	226	9%
	Extremely unlikely	120	5%
	Don't know	5	0%

3 - The care of patients/service users is my Trust's top priority.



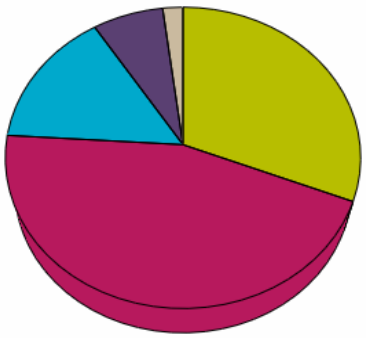
	Base	2583	
	Strongly agree *	1025	40%
	Agree *	1062	41%
	Neither agree nor disagree	284	11%
	Disagree	184	7%
	Strongly disagree	28	1%

4 - I am able to make suggestions to improve the work of my team/department.



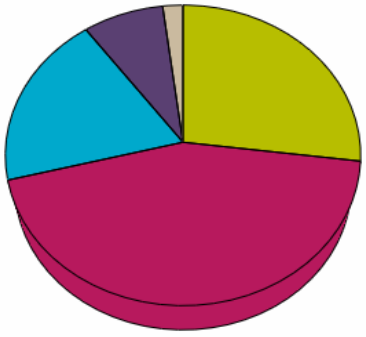
	Base	2490	
	Strongly agree *	826	33%
	Agree *	1158	47%
	Neither agree nor disagree	334	13%
	Disagree	147	6%
	Strongly disagree	25	1%

5 - There are frequent opportunities for me to show initiative in my role.



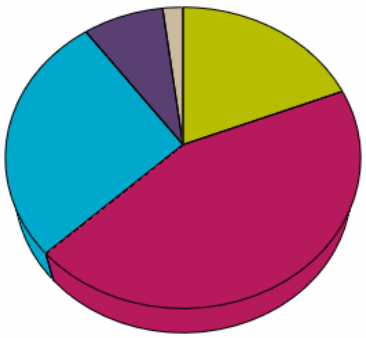
	Base	2559	
	Strongly agree *	784	31%
	Agree *	1150	45%
	Neither agree nor disagree	391	15%
	Disagree	187	7%
	Strongly disagree	47	2%

6 - I am able to make improvements happen in my area of work.



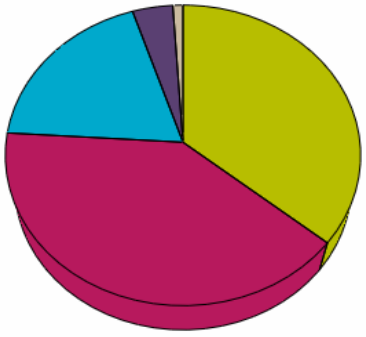
	Base	2514	
	Strongly agree *	683	27%
	Agree *	1095	44%
	Neither agree nor disagree	489	19%
	Disagree	198	8%
	Strongly disagree	49	2%

7 - I look forward to going to work.



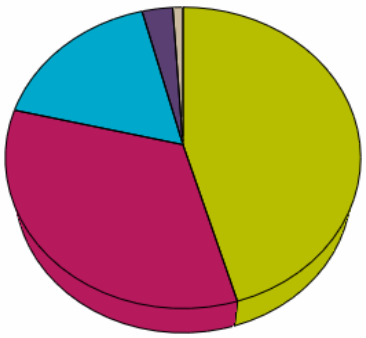
	Base	2577	
	Always *	485	19%
	Often *	1146	44%
	Sometimes	690	27%
	Rarely	204	8%
	Never	52	2%

8 - I am enthusiastic about my job.



	Base	2554	
	Always *	915	36%
	Often *	1026	40%
	Sometimes	487	19%
	Rarely	107	4%
	Never	19	1%

9 - Time passes quickly when I am working.



	Base	2563	
	Always *	1165	45%
	Often *	850	33%
	Sometimes	435	17%
	Rarely	86	3%
	Never	27	1%

Free Text Comments

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

Extremely likely

Very focussed on service users, families and carers. Well audited and act upon required actions.

From personal experience with family members I am aware that services in other trust areas are not up to the standard our trust provides.

Good friendly attitude.

Working to support clinicians leads me to value them highly. In our digital age my daughter in the USA asked me to recommend links for her friend in Edinburgh who had a relative in the TEWV area that needed help. Sadly people, I believe cannot directly access TEWV, but have to go via primary care referral.

Positive enthusiastic caring staff.

Specialist services available, range of locations, high standards.

All staff are helpful and do there upmost to see that needs are met.

Friends and family are currently at the heart of the trust values.

Empathic care provision.

Positive, caring environment, excellent staff.

Dedicated staff.

Staff are dedicated and caring.

In most departments a professional and caring service is provided. I do however feel that at times this is not the case regarding inpatient stays where pressures to discharge at all costs with little assessment and formulation being carried out put patients at risk.

Good quality service in general.

There is a positive focus on psychologically informed care and treatment.

Really good staff.

Most of my family work for the Trust.

TEWV is person centred and attentive to individual needs.

I have given this reason as I know that the Trust give their patients extra care and try their very best for them.

Timely assessment of needs.

Caring, compassionate staff.

I know that I can trust the ethos of the hospitals and of the Trust itself. Nurses here really do believe in 'making a difference together' - even in very trying times.

There is no alternative to recommend it’s a case of care or no care.

I have worked for the Trust for many years, and seen how the service has improved.

The only exception I would make to this is Forensic Learning Disabilities - in that case I would say 'Extremely unlikely'

My experience is that the organisation as a whole puts patients first, and the teams are conscientious, caring and professional.

The Trust provides safe effective care and treatment for individuals suffering with mental health needs. The recent CQC inspection provided good feedback in relation to services provided.

Already have, due to the success of my own driving therapy - daughter has similar issues after a recent car crash.

Turnaround in patient services offered is very quick and appears to be effective.

The CAMHS crisis team are brilliant.

Because the service we as a team provide is second to none.

It is the only local MH Trust I would be more likely to recommend if it was MHSOP that was needed.

As I know that the staff are genuine caring people that just want the best for their patients.

Referrals are dealt with promptly and staff are friendly and professional.

TEWV provides very high quality of patient care. Very efficient communication between teams which means things are less likely to be missed. Most patients I have come across are happy with the treatment they received while in these hospitals.

We aim to deliver the very best care using not only all of the targets and strategies, but by having the very best staff, well trained and well treat staff deliver great results.

TEWV is the only mental health Trust in my area to choose should anyone need help.

Short of staff and constant form filling.

Standard of care that is excellent, robust quality and governance in place with good outcome measures.

Having worked with the Trust just four years now I continue to be impressed by the care given to both inpatients and community.

The learning disability team in Darlington is particularly good and I am proud to be a member of the team. Every effort is made to keep in touch with the needs of service users. Every Monday morning we have a meeting of professionals to express our concerns or positive experiences with others so that the rest of the team can be aware of what is happening in the community. This is just one example of team working within Darlington.

I don't trust private organisations who have to consider the needs of shareholders above the needs of patients.

Well run and competent staff.

My reason is that the service is highly efficient and has provided my family members with the appropriate outcome, however, accessing mental health services has proven quite difficult.

Family member with mental health issues.

Caring organisation with high standards.

The clinical aspects of the service and caring attitudes of frontline staff.

Staff are very helpful and kind. They are keen to provide the best possible care for all service users.

There is no other option for mental health.

Staff within our unit treat patients and carers with great dignity.

My colleagues are extremely professional and I would not hesitate to recommend to a family member or friend.

A very patient and carer centred Trust.

I think there are certain areas of the Trust that are not as up to date with current practices and would therefore have some reservations, however I do believe that most of the areas excellent care is provided.

Based on the professionalism of the members of staff working in AMH, not the waiting list times.

Likely
Depends which area of the Trust.

Depends on service in my local area. Have had positive experience with family members in CAMHS service and MHSOP. Not as positive about my local Adult teams.

I think the current staffing levels restrict the quality of care available.

Committed and capable staff but ward staffing levels are often inadequate which could lead to errors.

I feel that the nursing support is brilliant.

This would very much depend on the care needed, which speciality, individual service. There are inconsistencies in service delivery and quality.

It would depend. Some wards at Roseberry Park claim to be patient focused but they are actually money focused! So although nursing staff are fantastic at what they do, they are limited due to constantly short staffing levels!

Staff are efficient in their work, and I have noticed that they are also reassuring to patients in times of what must be distressing for them when going to hospital.

It would depend on what they needed treatment for and which area they lived in, I do not feel that there is equity of service in all areas, however they wold have little choice but to access TEWV services if they are within the TEWV area.

Good organisation.

Quality, safety and staff attitudes are pretty good.

There are some excellent clinicians working for the Trust, however there is an ethos in some teams of paperwork being more important than patients.

Although there are changes to my service I would hope that our care remains the same.

Some areas are understaffed and the current waiting time to be seen would not be acceptable to me.

Although it is unlikely that my family or friends would receive treatment within this Trust as the majority of them do not live within the Trust boundaries. What I have seen from staff when I am on the wards or speaking to them is that they are very caring and committed to giving the best treatment available.

Needs more staff at times and quiet ones get push to back by demanding patients as they take up the available staff.

Quality of clinical care is very good.

I would rather an older person be cared for TEWV than the acute hospital as it is more holistic.

It would depend on which part of the service I was recommending.

However I would personally 'keep an eye on things' as different practitioners develop different interventions.

The staff are excellent, but we are short staffed.

Provision of service and quality standards.

As a MH/LD Trust it is the main, if not the sole provider, in the area so it is not much of a choice!

I think the staff are dedicated and motivated. I think resource in some areas is lacking – especially psychology, and folk can end up waiting month upon month for suitable interventions. Staff are more able to deal with the crisis stage of an illness.

Caring staff, good buildings and facilities.

I have not had experience of having care or treatment from TEWV.

TEWV Trust is developing its services to improve service user experience.

Depends on which service.

Family have had poor experience with psychology services, otherwise would be 'extremely likely'

Because I know how dedicated myself and colleagues are to providing a good service.

There are problems with the service provided by TEWV at the moment but we still employ some excellent clinicians. I believe friends and family would receive a good service because the clinicians will want to help. However, systemic issues in the organisation of the Trust make it more and more difficult for them to do so. I believe the Trust would provide a good service against the odds.

Obviously I can only speak from experience....the nursing staff are incredibly understanding and caring treating patients as they would their own families, its most impressive - HCA are included in this comment.

Overall I would encourage friends or family to seek help/care from TEWV however, it would very much depend on the team/individual they were to see. There are some (although very few) teams/individuals that I would be distressed to hear were involved in the care of a family member.

Overall I think TEWV do a good job - but there are issues with delays due to capacity of teams and limited resources which don't appear to be improving.

I would recommend the service I work for, but recent experience of children's mental health services has been a let-down and I would not recommend their care.

The Trust is the only provider in the area. My family and friends have mixed experiences with the Trust.

Whilst I think TEWV Trust offer a great service I think many are under resourced and some services are dictated by what the CCG says has to be offered, i.e. how can you offer a psychological therapy service without no counselling, EMDR, IPT or other forms of treatment/therapy. I don't believe one shoe fits all and that is why we need to offer a varied of treatments not just ones that suit the CCG or the service. It shouldn't rest on a postcode lottery for patients i.e. one IAPT service will offer other treatments depending on what area it is in whereas other services are vastly under resourced.

Despite the ongoing difficulties with staffing levels and high demand I do still believe that we are an excellent team and can deliver an excellent service.

The care is good, with hardworking, caring staff.

Lack of options.

It’s the only choice for treatment in this area.

Easy for me to visit and is the only hospital of its kind in Middlesbrough.

It would depend on the team. I would be extremely likely to exclude certain teams for specific services.

The standard of care is great and clinicians seem committed to their jobs.

There are no other local services available.

I would be extremely likely to recommend my team to others.

Most services are very good but there are pockets of practise that still need improving.

Although I genuinely believe that the service is become less quality due to the increasing demands being placed on its staff.

I would be happy for my family to receive care from community teams but have concerns about in-patient care. This is not a reflection on the in-patient staff but I am acutely aware of the stressful environment they are having to work under, poor staffing levels and allegedly at times clients behaviours due to illicit drugs or alcohol being brought onto the wards.

Committed staff, just under-resourced.

I work with some very dedicated and motivated clinicians who pride themselves making a difference.

From my experiences, most services have been excellent, however a family member did not have the best experience.

I'm aware that a colleague’s family member received quite a poor response from community services when he was mentally unwell but once the police intervened, the inpatient staff were very helpful.

Stability.

Variance of service depending on locality.

I don't think all services are the same in the way they treat people. I would recommend adult/older and CAMHS services.

Don't have experience of the Trust from a patient's point of view so difficult to say if I would recommend or not. Likely too just because it is on the door-step.

I have not put extremely likely because I feel crisis teams could appear more responsive and caring.

It would depend on the area and service as there remains to be patches of excellent work and patches which require improvements depending on specialty and geographical area.

If not TEWV, the distance to travel would be exorbitant.

I do believe that they would receive very good care and treatment.

Because of necessity rather than a choice of services available.

The amount of paperwork expected to be discussed with patients on admission needs to be revised and reduced as it does not appear the individuals mental health has been truly considered and is being overshadowed by the need to meet targets.

The crisis response is often commented upon negatively by clients.

It would depend on the diagnosis or condition.

I on the whole would recommend TEWV for care or treatment to my family or friends, however I think as in every workplace there are certain individuals who show more empathy and respect to service users than staff who don't. I have witnessed this both as a clinical practitioner and as a mother in law of someone who has accessed services from TEWV. Once staff found out through my son in law I worked for TEWV staff stated they knew me and advised my son in law to speak to me and access support from me as I know what I am doing. I felt this crossed the line between clinician and family member and it put both me and my son in law in an awkward position.

Depends on area as our services are very variable.

Due to locality there are a lack of resources in the area, lack of in-patient beds is another issue often families have to travel quite a distance which can be extremely difficult given the lack of public transport, this is a major issue for the elderly and those families who have no transport of their own. Inconsistencies across the location in what services are available to service users, access to psychological therapies is an issue.

To be honest there is no other MH Trust locally so wouldn't want them to have the inconvenience of travelling elsewhere if they were unwell.

While the TEWV is a vast and successful organisation bringing in quite a few innovations in the way it works, I however remain wary of it's top heavy management style and over-reliance on policies and procedures to the exclusion of professional judgement of staff.

The care is excellent however there are many problems getting a bed in local area.

Poor staffing levels prevent patient contact.

I have two friends with teenage daughters both of whom (independently of each other) have been referred to the Trust but had experiences that they have described as unsupportive, unhelpful and patronising. I have tried to encourage them to raise this through formal channels so that services can be improved as I know how hard professionals work to achieve the best outcomes, but do feel dismayed by their experiences. However I would still recommend TEWV to anyone needing care or treatment.

I think some areas are better than others.

The organisation expects a high standard from its staff and does much to support staff development and well-being.

I do believe that clinicians are stretched for time due to the demand of completing comprehensive documentation which reduces time with patients and increases workload stress. I have given a score of likely as I believe that the staff across the Trust in corporate, support and clinical services have the needs of the patients at the heart of their practice.

It is local to my family and friends. I would be able to interface with services and iron out potential problems in accessing and getting best from service. I do not think service is 'to be avoided'.

Clinicians in the service can be good and MH problems can be diagnosed and treated effectively. Clinicians in the service can be supportive .

This would depend on what type of service they required and which locality they lived in.

I would recommend local services. However, I would not always recommend other parts of the Trust.

It would depend on service, location etc.

The Trust is now so large that if mental health services are required, there would probably be no other option.

Neither likely nor unlikely

CQC are limiting the care we can give by least restrictive practice. Personality disorder is not compatible without boundaries or structure.

I find that this is a question that cannot be answered. For example TEWV is a very large place encompassing a wide variety of services. Would I recommend our unit? My answer is a solid YES. Would I recommend some of the wards our clients have been on, when they have been very ill? Then it is a solid NO. The difference between the delivery and quality of care provided is so extreme that I feel nobody can truthfully and competently fill this survey out unless it is on a strictly individual basis regarding X unit, Y community team, Z drop in clinic.

I don’t have any experience of any other Mental Health Trust so cannot compare.

I've had some recent experience of having to support a family member to use TEWV services and my experience was mixed. At the time of crisis I was disappointed by the response of services to the individual's need however once the out of the crisis the services delivered have been helpful and supportive.

Family and friends live outside Trust area.

There is currently no choice, therefore recommendation is pointless as is this question.

It would depend on the service they required.

Depends which bit of service needs treatment in.

Depends on which hospital they were receiving their care from.

Depends which service they needed to access and where.

Unfortunately, my response has gone from 'Extremely Likely' to what is neither likely nor unlikely as I have seen in my local area a deterioration in service provision, due to staff shortages, and this not necessarily linked to there being enough nurses, simply that there appears to be more sickness but also that some positions/vacancies are not being filled very quickly in this NEY area.

As I have said before it all depends upon the service and also the workers you come into contact with. I have contact with many teams and they vary significantly in quality. I cannot stress enough however the effect of the quality of staff the person has contact with.

If they needed treatment then if this was the place they had to come to then so be it.

Staff are rushed with too many people to see and little time to reflect on treatment, therefore I might advise friends and family to seek private treatment if they could afford it. Also it can be difficult to be seen as referral criteria are quite tight.

Some care is excellent from teams, some mediocre depending on skills and energies of teams.

Personal experience as a carer - things improved slightly but still feel that improvements could be made in basic communication.

Would depend on personal knowledge about good vs poor team's reputation.

Main reason is staff consistency and high rate of sickness, this effects care of patients.

People don't tend to have a choice in where they receive treatment. It is usually determined by where they live.

Variations across the Trust.

At times I think it’s a bit to clinical for certain patients, but as I have worked in most areas of social care, I think Ward 15 Northallerton is an excellent place for acute psychiatric care.

As this is the only provider of secondary mental health care there is no option.

It would depend on which area, Durham and Darlington I would be reluctant to recommend but Teesside more likely.

It would depend upon which service they would require, some are clearly better than others.

It would all depend on what team was providing the care.

I would say likely in terms of the quality of my colleagues, but unlikely in terms of the volume of work and pressure staff are under which is compromising the quality of service.

Difficult to answer as I would not recommend it as a place to work. The staff who work with the service users every day do a great job and regularly go above and beyond but as we are expected to provide 'more for less' I wonder how long this will go on for.

Experience and care they would have would vary according to staff.

We are all trying our best but there is simply not the time nor the resources to make you feel that you are providing the service you could 3 years ago.

As a professional in my current place of employment there are areas where care provision is, in my opinion, inadequate and I have voiced these feelings. Personally I have bipolar disorder and am nursed to an extremely high standard by my CMHT.

From a carers perspective - it is very frustrating when clinicians work term time only or go on sick leave. As there is no communication with carers to let them know next appointment (after it is cancelled by service) and had to wait 4 months for another appointment. This was after I made contact to the team as a carer not a professional, which felt awkward.

Although beneficial there is a lack of resources in some areas at present.

Whilst the organisation has some positive attributes such as excellent training opportunities and great support r.e. estates, financial stability, I feel the systems that have been created are over complicated, I understand many of these systems are national but they are so time consuming and contributes to inefficiencies which takes time away from face to face patient contact. I am sure the Trust is as good as any other but the NHS seems to have over-complicated systems.

Some staff in a specific team in North Yorkshire can be quite abrupt, generally staff good though.

It would depend on which service they would need.

Complete inconsistencies in care and quality of this. Poor management and leadership - spending more time 'meeting' than 'doing' - standards need to be pushed and staff need to be supported to make changes and held to account. Too often issues or poor practices are raised and little is seen to be done. Staff need to be encouraged to participate and actively contribute to shaping services - too often staff are overlooked. Those willing to stand up and share their views/ideas often viewed as difficult. People in senior positions who lack the ability to lead people - we need more leaders especially clinically - management stuff is obviously important but the benefits of clinical leadership are far more so especially when driving up clinical care and quality e.g. NURSE CONSULTANTS!!!! Knowing what I know about working in TEWV I would imagine that those receiving care would do so inconsistently - there are some excellent clinicians, who provided A* service, who demonstrate the 6C's in all that they do - for those I would definitely recommend but for some the experience and quality of care would be far lesser than what you would/should expect.

More likely to suggest getting help rather than where they should get it.

My own practice is within the LD field. Currently have a relative undertaking MH nurse training and feedback in respect of practices observed in this field have not been great.

Waiting lists so long that I'd possibly encourage them to go private, unless they would benefit from a course/group.

There is no other option is there? Whilst there are dedicated, knowledgeable and caring staff they are over stretched and have to spend increasing amounts of time updating report after report at a computer.

I have no experience of Mental health services and LD services are in a process of huge change at the moment.

My family do not live in this area.

It would depend what type of care and which service they required. Waiting times for some therapies are lengthy therefore I am likely to recommend accessing therapy elsewhere/privately.

I feel overall mental health services are basically not adequately funded meaning that clients in general see staff who are extremely dedicated but very overstretched.

Due to cut backs on resources and staff.

It's the only MH Trust in the area that could provide care - no choice.

Depends on which service and which member of staff.

Not in a position to make a clinical judgement.

I think it is difficult for people to access the right services from the outset and often can't get the help they need without knowing how to negotiate the systems for example -they need a psychologist but have to go through the graduate MH workers first. I would add though that I think TEWV is better than most and that the QIS is fabulous for redesigning services (as long as the whole systems approach is used)

Unlikely

This is dependent upon the service required. I believe there are difficulties in the provision of care in relation to staffing and the pressure associated in prioritising system attainment. This has been particularly evident since the introduction of payment by results. Also there are responses in supporting staff when staffing and workload issues.

There are lots of positives about the care given at Roseberry Park most of the staff are caring and compassionate but the bottom line for me is that there are not enough staff on the floor to attend to all the patient's needs. Patient safety should be of paramount importance but there are many many times when there is not a member of staff in sight.

Constant reported staff shortages, means proper care, less safe environment and patients cannot get out on escorted leaves.

Chronic staffing shortages mean therapeutic work is curtailed, also short staffing means wards are not as safe for patients as could be.

Staff too busy and too stressed partly because spend so much time in front of screens.

The service locally is extremely under-resourced and staff under immense stress. Inevitably this affects the quality of the service.

Due to staffing I would tend to not recommend.

Currently the referral systems and access to appointments seems to be a long winded process where they may see several people before actually reaching treatment and very repetitive in the process, there are also several ways of getting to this point none of which seem to be standardised and there are different understandings depending on which service, i.e. via targeted services, via crisis team or via GP and screened by tier 3.

My ex-partner was seen by a team in North Durham and expressed they were unimpressed with the service.

Staff are given posts without the correct training and experience, it is only a matter of time before there is another serious incident.

The staffing levels within adult mental health are too low to deliver an effective, efficient and safe environment. Patient care is compromised. I would not be comfortable with letting my mum be cared for here. It is an unsafe environment. The staff simply do the best they can with the numbers, but the staffing levels need to run as 5 on the day; (2 nurses, 3 HCA's), and 3 on a night; (1 nurse, 2 HCA's). PICU's should run on 6 staff day and night, (2 nurses, 4 HCA's). This is because on PICU's time of day makes no difference to the level of staffing required. I don't work on PICU, however I cover it every now and then, and frequently provide response. Staffing levels on AMH are too low to facilitate sometimes any response at all, or at other times certainly insufficient numbers, or far too few male staff. It is an inevitably a staff death will occur due to the defined staffing levels being insufficient and unsuitable to ensure a safe environment, and one that is fit for purpose to deliver the standard of care that should be attained.

It no longer feels as though patients are at the centre of what we do, but everything is more about what is funded for (or not).

Long waiting times for treatment.

The community adult teams are in desperate need for stability, staff and support so that we can offer this to clients we see. Community teams are treating some very desperate, disturbed and difficult patients however caseloads of 50+ are unmanageable. Staff are constantly hearing horror stories of abuse and trauma and managing people who self-harm, suicide attempts or who are extremely angry at the world. Staff turnaround is high, particularly team managers. In focusing on management targets, such as the very important payment by results agenda, the criticism is high for targets missed regarding paperwork with a lack of understanding of what staff have done when they haven't done there paperwork. Referrals to the team are large and treatment takes time. More staff needed in teams at all levels (care coordinators, Psychologists, admin etc), more space (rooms) to see clients in (to avoid travelling) and staff need more supervision and kindness from management. Care coordinators within affective teams are excellent clinicians, who are very competent however caseloads are too high and therefore they are unable to treat people the way they need to. Although community teams should be treatment teams, the teams are running like a crisis team, reacting to patients rather than being proactive in treating people. Staffing is the major problem, if anyone is off sick or on holiday in the team the team is in crisis, we have no help if short of staff.

Sister was referred to Crisis team and they did not follow up on the help she needed. She had to contact talking changes herself.

Due to the waiting times currently and the amount of staff leaving the service that are not

been replaced, therefore putting a huge amount of stress on staff that remain - 'the old faithful's - myself included.

Friends yes family no due to working for the organisation and maintaining privacy.

Staff ratio looks good on paper but not hands on.

I feel the trust is cutting back on services therefore the quality of care is not there like it used to be.....it is more bothered with money than people!

In my recent experience working as a member of this Trust for four years, I have seen a growing trend in organisations and teams working in a way which displays exclusion based criteria. This leads to individuals being referred into service, being transferred between multiple Teams.

Understaffed, not enough time to give quality care.

Under-funded; particularly provision of Psychology care (excellent quality but limited resources).

My experience is that delivery of services/appropriate interventions are rushed and often given lip service as a result of audits and timescales as opposed to positive outcomes.

Staff not resourced or supported enough (no time, infrequent supervision, massive case load, targets, too much admin with PARIS etc) to give good quality care.

I had a bad experience (being a carer for my wife who became a service user - adult services).

Extremely unlikely

Environment, too noisy, too small, not enough to do.

This answer reflects being disillusioned with the management team and not the clinicians per se. The clinicians for the main part give excellent service, but all the management seem to be interested in is whether the 'targets' are being met. These targets are arbitrary and don't reflect any quality at all.

Do not feel valued by the Trust.

I would not recommend TEWV to family or friends for treatment because of the lengthy waiting times.

Staffs attitudes.

It's disappointing that there is no choice.

You persistently ask this of me and the answer remains the same. TEWV as an organisation has lost sight entirely with the notion of CARE. It is purely a business; patients and their wellbeing are an after-thought. Staff given cursory attention. The fact that for mental health care provided by another organisation is almost impossible to be had makes this whole question moot pointless and like so much that is obsessing with TEWV purely a further Tick Box exercise. Spend less money on this nonsense and more on patient care please.

Caseloads are essentially too high to provide quality interventions in a timely manner.

Services have been destroyed by recent reconfiguration resulting in huge amounts of extremely experienced staff leaving care co-ordination posts. Remaining staff are overwhelmed, highly stressed, and unable to provide quality care due to mounting demands.

Cross Lane Hospital only offers acute care and does not coordinate caring for patients in the community after discharge. Also, diagnosis is changed from Bi-Polar to Personality Disorder, which means that clinicians do not have to help patients and they are simply discharged into the community.

Don't know
I have no family or friends who would need care in this kind of setting.

I do not work in a clinical area, so I do not know.

I have never received care or treatment from TEWV so am not in a position to comment.

It entirely depends on where they live and whether any treatment boundaries would be compromised for them through using a service in which I was employed. People can be inhibited by thinking friends or family may be privy to information about them even if they have been assured that isn't the case.

Although I work for the Trust, it's in a non-clinical environment, hence I don't feel I can comment about our clinical treatment.

How likely are you to recommend this organisation to friends and family as a place to work?

Extremely likely
TEWV is a supportive, encouraging, organisation to work for. The development of its staff is very important and staff wellbeing is integral to its beliefs.

Great culture with strong leadership in place.

I work with some very dedicated, hard-working people and the NHS still provides a very good staff support system, even though this is somewhat eroded by the current Government's lack of understanding with regard to necessary funding.

Compassionate and understanding people. Very interested and interesting to work with. Lovely atmosphere.

Great culture and management.

Good working environment and opportunities for development.

Family friendly, strict policies, positive secure working environment.

It is a dynamic and well led organisation that has high standards for care provision. Anyone wanting an interesting and challenging career with great learning opportunities and the chance to really make a difference for patients would enjoy working in TEWV.

Support available from other staff.
TEWV is a Trust which tries hard to take good care of their employees.

Support, help and advice is so valuable.

The NHS is a good and fair employer, and TEWV has one of the most pleasant attitudes to HR and employment I have ever known. People are treated as people and not numbers. If you are ill or have suffered bereavement, they will do everything in their power to ensure you can keep working for the Trust. I don't know of other employers who would do that.

From my experience it is a great place to work.

I have worked for the Trust for over twenty years and enjoyed the learning experience's I have gained, as well as making good friend's and support I have had.

Staff are welcoming and friendly.

Great Trust to work for, very accommodating.

Good management, support and training, positive working environment.

As NHS Trusts go, this is one that is still managing to maintain some aspects of the importance of human relationships at work despite the cuts.

I have never worked for an employer who seems so dedicated to maintaining a happy healthy workforce. I am also very impressed with the HR/Induction process which was very efficient and in general was all in place prior to my start date so that I could start on my job straight away. The IT team are very efficient and helpful and it does not take long to have IT issues resolved which can be very frustrating in other Trusts I have worked in.

Great team, great manager, always involved in leadership decisions, great peer support, challenging yet also fun and rewarding.

Having worked when part of NYYPCT there is a clear difference with regard to investment in both people and estate towards providing a better service.

Good Trust, well led.

I have always been fully supported within my role, I feel valued as a member of my team.

The organisation attempts to keep staff informed and supported.

Supportive to its staff.

I have worked for a number of NHS Trusts and TEWV compares favourably. In my personal experience I have felt supported to develop professionally. There have been times when I have felt both unsupported professionally and in fact victimised, but those times have involved particular individuals and have not been representative of my overall experience of working for TEWV.

Well managed organisation, fair employer.

Having worked in several local Trusts I am confident in recommending TEWV as, in my opinion, they are the best of those I have worked for.

Always found support for my work across a range of different roles and managers.

Good opportunities for further study.

Where I work staff and management are brilliant to work with and so friendly.

I enjoy working there and feel that I am fairly treated and paid for the job that I do.

It depends on the area of work they are applying for, the team I currently work in is really good, but other areas I would be less sure on recommending.

Having worked at the Trust for the past 25 years I would recommend working here to family and friends. I believe that I am provided with first class training and support.

Although we are worked VERY hard and sometimes given competing and overwhelming lists of things to JUST DO, TEWV senior managers do take time to understand the whole problem and will work with you to get a solution once they know the issues. My concern has mostly been with middle managers who don't think and just implement.

It is a very supportive organisation truly living and working hard at embedding the right values and behaviours.

I already do so when I meet anyone interested in becoming a mental health professional.

I am new to the Trust and think it is an excellent organisation with great leaders.

Good place to work.

Very supportive colleagues. High standard of teaching.

I have worked for over 20 years for the Trust in its various areas, and I feel valued, included and supported.

The leadership in this organisation is outstanding.

Pressure of work.

Whilst it can be a really busy place to work, the standard of care, quality, governance and assurances mean that clinicians are protected in terms of what they offer. TEWV is also very supportive of new learning, career progression opportunities, aims to be transparent in the processes it uses when there are difficulties and recognises staff who are achieving well, supportive of staff who need this additional input.

Think the Trust offers support to its staff.

Likely

Depends which area of the Trust.

Need to invest more in how notes are documented, at the moment clinicians, doctors and consultants are losing a significant amount of time to typing up and clicking through PARIS forms.

I feel that at interview we really must explain and get across TEWV principles and how important they are as I think sometimes especially for staff that merge are very unaware and poorly communicated with.

Better working environment than other local mental health Trust.

Very good training therefore very good potential to provide great care.

As above, this would very much depend on the locality. There are inconsistencies in leadership style, investment in staff wellbeing, opportunities for development and general culture, which would mean I highly recommend some areas, but would strongly discourage others.

It would depend on which part of the service I was recommending.

Again some areas and services are much better than others, overall the Trust vision and goals are fantastic but pockets of poor leadership and management sour parts of the Trust.

Purely because of the pay and conditions attached to our jobs. The day to day management etc leaves a lot to be desired and varies from work place to workplace. We are asked to give more and more of ourselves and own time to the work that we do and burnout rates are high!!

Managers are encouraging and supportive of staff who want to do training.

Again it would depend on which team they were hoping to join, as a whole I think TEWV are good employers but some teams are very under resourced and over stretched, for instance in my experience there has been a huge difference in workloads and resources within some teams.

I believe they will be supportive of care.

Staff are generally valued.

Can be very stressful when not enough staff.

Working for TEWV is good reliable employment and there are many opportunities to progress. I have not ticked extremely likely because I feel the NHS as a whole does not value nursing staff and nurses are underpaid. I have got steadily poorer (in real terms) year on year since I qualified. I also feel that the recent changes to the NHS pension scheme are unfair and was horrified to find out that the terms of my pension are open to change without my consent whenever the government feels like it. I am left feeling very concerned at what state my pension will be in when I retire. The most recent change left me paying more, working longer and receiving less. Also, in my current role as manager, I get paid less (when taking into account) enhanced hours than my staff for much more responsibility and work. Also, if I was to move into the area of clinical specialism I would still only move to band 7 and be getting paid less than a staff nurse that gets plenty of nights or weekends. As a result I am considering moving into the private sector or abroad. I am not the only one.

It would depend on the team. I would be extremely likely to exclude certain teams for specific services.

Generally the Trust is a very good employer in comparison to other NHS Trusts. But sometimes its size means there are some very centrally driven decisions/actions that create difficult cultures and relations.

Certain area's I would not want support from.

I have found TEWV to be a good employer.

Although there are some teams with poorer dynamics there is positive attitude to ongoing support.

Positive experience of Trust as an employer.

Depending on their work area.

Terms and conditions.

Several family members have had poor experience trying to join the nurse Bank - has put them off and did not present the Trust in a good light.

Wide network of opportunities and makes efforts to value people (e.g. extra days leave) relative to other Trusts, despite obvious constraints and pressures.

Positive work environment with hard working people.

I don't really have any reasons to not recommend anyone but have also never really worked out of the NHS so couldn't compare to anything else.

I have always been happy at TEWV however over the past 18 months the number of operational changes to our service and changes in managers has been unsettling for the whole team.

Dependant on where working I would recommend working for TEWV.

I think this is too general a question to answer, I enjoy my job and deal with the stress. Many staff appear to have very low morale, due to various reasons but again in my opinion, mainly due to the pressures of work being placed on them.

No Trust is perfect. We're better than many other MH and LD services.

However I feel the organisation is stretching the parameters of people's roles beyond what is reasonable - expecting far more from the staff in what was not previously the responsibility of someone of a set grade. – i.e. risk been seen as not paying people for the roles they are doing within the boundaries of agenda for change. Also feel the Trust needs to look at solutions to enabling staff to deliver the care rather than been tied up on computers completing documentation all the time - know some of this happening but need better more mobile solutions.

Psychologists are valued and seen as central to the work of the Trust and that makes for good working relationships. There are structural/management issues that could be better which make me hesitate from validating the extremely likely box.

It is a good place to work I love it.

Caring friendly staff team.

Excellent training potential to develop skills.

I think on the whole the Trust is a great place to work and staff are largely valued. However, with increasing pressures in the NHS it does feel that more and more is expected and there is not the resource to accomplish what needs to be done leading to a stressful, working environment.

It would depend entirely where it was and with whom.....many managers are terrific but some are full of their own importance and NEVER listen to their staff.

I feel like TEWV is a very well run organisation.

Again would depend on the service area as some management structures are based on fear and number crunching rather than truly capturing the Trust's values. Sometimes the business model overtakes the quality of care - the numbers and ticking the boxes are more important which was the main issue highlighted within Winterbourne report. Although PbR and evidence based practice is important and needs to be taken into consideration, so does service provision and the welfare of our clients.

Depends on locality.

It's generally very good.

If not working for TEWV, would have to travel to Leeds, Cumbria or Newcastle.

Because it is place I have worked for a long time and still enjoy my job.

As long as I believe they can make a change and not just want a free ride.

TEWV is more financially secure than most Trusts.

The new sickness absence procedure is a real concern. I have not been absent for 2 years but need a planned operation in the near future. As a result my absence will be deemed at an unacceptable level as it is likely to be for longer than 9 days (even though this is my first absence in over 2 years) and I will be disciplined for this. This is completely unfair as I have worked extremely hard for the Trust since I started and have hardly ever needed to take time off. I am very worried about this.

Communication tends to be a recurring issue, with unnecessary secrecy given to the most unlikely scenarios. Apart from this, I love working for the Trust.

This job can be quite rewarding.

I think the pressures are as any NHS Trust - I think TEWV have good core values and principles.

As above where staff believe they are treated as automatons who have to follow decrees from the top, to the detriment of good care on the ground.

I believe that TEWV is a great employer and invests in its employees to develop as this will ultimately have a positive impact on the service user. I believe there is room to improve in trying to minimise some of the demands on staff with more coordinated awareness of the various departments projects and inter-communication.

The team I work in is well functioning and supportive of me personally. There are few places I would not advise my family and friends to work but generally think it is a good employer.

The work is intense but enjoyable. Conditions are generally good.

Neither likely nor unlikely

We are classed as numbers....and is documented as such.

There are positive and non-positive aspects of working for TEWV.

It would depend on the service in which they were interested in working.

Recent changes in our team have left us feeling neglected, without a role and not involved in the change process. Our role has been replaced by a new team and we have been left high and dry with no support from out directorate. I am considering my future with this Trust.

On a professional level I feel that some staff do not provide other staff with the support they require.

Some parts of Trust give you no support when things go wrong. Loss of focus on patient care - too risk averse and too many cuts.

TEWV is within the NHS. Who knows how long that will last, and what will replace it? TEWV feels to me like a well-managed organisation, but political interference puts that constantly at risk.

It would depend on which unit, I would not advise friend or family to work for the acute inpatients services as the staff are not respected or supported by management. Forensic is a great place to work and I would advise friends /family to apply.

There remains an old boy network in TEWV and the people who get on and do the job are bypassed for the chosen few. Jobs are no longer advertised fairly as those chosen are put into an acting positions, and looked after even with talent management it sounds good but, still lacks fairness.

Lack of proper breaks for nursing staff.

I think as a place to work TEWV is brilliant, they invest in their staff and I personally have had ample learning and development opportunities - there are huge benefits for working with TEWV including a commitment to health and wellbeing of its staff. What swayed my answer is the fact that staff - those out there - on the coal face, shop floor (whatever you want to call it) are often overlooked and ignored when it comes to driving up quality, decisions are made top down - it's like the basics in change management are missed out at the most crucial point which leave staff feeling completely unimportant and undervalued. For someone who is committed, motivated and enthusiastic this approach zaps it out of you. I appreciate some decisions have to be made, and can only be made at the top but I don't understand why those decisions, that would probably be best solved by those experiencing the difficulties/barriers/concerns etc cannot be done so in COLLABORATION between clinicians and leaders/managers. We talk about interdependence, partnership working with others yet for the most part feel as though there is a massive divide between team members and management (in the same team/service).

For a clinician working within the NHS, they are now expected to do more and more paper work, some of which is duplicated, giving less time to spend with their patients. There are a lot of new ways of working which are good, open discussions among other disciplines within teams, to bounce ideas off, all avenues have been exhausted.

I think I would still recommend working for TEWV, but I currently don’t have the same passion about the Trust as I did regarding its treatment of staff as I did due to a situation a colleague was in and the way it was handled by TEWV.

If they need a job then it's better than nothing.

I am very passionate about, and love my job, however staff morale, poor staffing levels and lack of appreciation for work above and beyond makes work difficult and stressful at times.

The staffing levels are so low I'd invite literally anybody to come and help out. Excluding those I care about, wouldn't want harm to come to my relatives and it's simply too unsafe working in TEWV.

As opposed to the last time I completed this survey, my response is less enthusiastic. I feel overworked and stretched at work most of the time and do not feel as supported as I once did. I am also concerned that nurse pay in real terms has reduced year on year due to not receiving a pay rise for several years, I acknowledge this situation is NHS wide and not unique to TEWV but regardless, this is a major reason why I am ambivalent as recommending TEWV to family and friends.

Depends upon what else is available to them. As a NHS Trust we are better than average I think. But that is not the same necessarily as being a good employer. And it varies significantly within the Trust.

Stressful environment to work in - expectations are sometimes higher than possible.

The expectation of inputting information into an electronic system which is badly designed and inefficient at the inputting stage makes a modern career feel like I work on production line. Not the career choice I hope my children will take.

Too much paperwork especially care documents that are really not necessary. People are spending time doing TEWV paperwork than caring for patients. When a new patient is seen, do they really need a Lester tool, FACE, SWEMWEB, Cluster, audit, etc the list is endless.

It would depend on the area that they wished to work, I would not recommend the Team that I am currently working in.

Staffing issues currently a challenge.

Personally I have had no problems but have witnessed a number of incidences where staff's mental health does not appear to have been taken into account when issues occur and senior management approach needs to be addressed.

TEWV is a big service provider with many challenges - especially in light of CCG commissioning. I feel that we provide quality therapy under very challenging circumstances (notably: limited time, resources - including rooms and buildings that are not necessarily fit for purpose.). Working for the Trust can be rewarding, but more than ever, it feels that the weight of expectations is becoming increasingly heavier - staff certainly need broad shoulders (and then some).

At present communication is not good from 'upper management' to staff.

Less so than previously, I am becoming busier and appear to have less resources, the admin/ bureaucracy expected is becoming ridiculous. I work with a lovely team, who are currently stressed and overworked and I am feeling also frustrated. Having to ask patients for all these feedback is getting silly, the amount of info to tell doctors on one day induction is silly, I am frustrated.

Stressful.

Pay and conditions are good, but working conditions and morale are often low.

Community work load is now unmanageable with no prospect of this changing.

The reason I would not recommend friends/family is due to high volume of work and the amount of time spent on Paris, not enough time spent with clients.

Of course it's a regular wage etc but there is no chance of promotion.

I think my answer is more to do with the area I work in, as overall other departments maybe more enjoyable places of work.

As above it is a good service however needs more staff.

Again, it would depend which team/service.

The Trust has become over managed, with too many targets and not enough support for staff. Managers are more intent on chasing targets than supporting clinical staff. Clinicians have lost influence.

As a Trust yes. As a department, probably. As a team, less likely.

Again inconsistencies across TEWV as to what training opportunities are available, staffing levels and pressures of staff to maintain expected targets can make staff feel that the focus is more on targets than service users. I am disappointed that in the next section there is no opportunity to give feedback about the reasons for answers given as there is in this section. So does time pass quickly at work, yes because staff are conscientious, compassionate put the service user first but are so busy they often miss lunch breaks, start early and finish late to complete work, I enjoy coming to my work area because of my colleagues and service users. Do I look forward to going to work, sometimes other times I experience a lot of anxiety and stress and worry because I may not have completed everything.

Unlikely

People expected to do the impossible. Leads to frustration for clinician and confusion for clients. Multiple letters offering appointments with different people as one example.

Staff are overstretched and underappreciated.

Feeling of constant threat by senior management around performance issues. No encouragement or support from senior management, no sense of being valued or respected. I don't believe that staff feeling anxious, paranoid and threatened is the way to improve performance.

There is a real disjunction between the rhetoric at the top of the organisation of quality, excellence, valuing staff, leadership etc. and what goes on at ground level where there is a picture of sometimes chaos, increasing absence of necessary human and physical resources and drives to minimise staff grades rather that truly encourage personal and career development. Efficiency is of course important but there comes a point where you cannot provide excellent services without employing and valuing quality staff, rewarding them properly, and providing the tools they need to do their jobs. The constant over-management of clinicians and focus on targets which do not translate from businesses such as the car industry to mental health services is not helpful. Higher level managers need to serve the clinicians below them by minimising bureaucracy not adding to it.

I find senior management punitive, yet I am expected (and do) demonstrate compassion to my staff and patients.

Bullying in the work place, no support.

Pressure and demands to meet targets , poor staffing levels.

Increased working hours in clinical areas, target driven health care.

Too much paperwork and stress.

More and more of clinicians' time is taken up by admin tasks (many of which decrease rather than increasing the standard of clinical care). We often get instructions from higher management to complete new training or to adhere to new clinical standards. No new time is created in our working day to allow us to do this and negative reactions to poor compliance seem to be passed directly to front-line staff rather than being filtered at team manager level, where they could be fielded by explaining that the team do not have time for them. Some of the new training is not fit for purpose (the recent training on Looked After Children was utterly irrelevant); any processes to check this before staff are told they must complete training etc. do not appear to be working. It appears there is poor prioritisation of demands at the level of higher or middle management. All of this translates into more pressure on clinical staff, making them feel unappreciated and un-valued and stopping them from providing the best clinical service. In addition there have been recent significant changes to working arrangements (introducing 6 day working and shifts) with minimal staff consultation. We are not able to object to these even though they are significant changes to our terms and conditions which have a knock-on effect to our home lives. This and the above combine to give the sense that we are no longer treated as valued colleagues, rather as staff who must do as they are told.

Too many managers, who are not clinicians making clinical decisions, too many managers who have bad attitudes and are protected by other more senior managers, blame culture, don't protect staff well enough, too much money spent on managers instead of clinicians.

Pressure put on limited staff leading to burn-out.

I have just accepted a new post and due to the issues experienced with the HR department and their inconsistencies I would not recommend this to a friend. Also if I was a new member of staff to the Trust given the way I was treated and the issues and difficulties I faced, it would actually prevent me from wanting to work for TEWV as it gives off a bad impression. This particular issue with me resulted in my new line manager involving a locality manager before the issue was resolved and took me three months to move from a band 5 to band 6 post due to HR errors.

I feel that over time my workload has become unmanageable and I do not see that changing soon. However, I think increasing workloads and unmanageable workloads are common in the NHS. I would not recommend working in the NHS to my friends and family. I do not have an issue with my individual organisation, just the NHS as a whole.

The wards are getting dangerous, and the severity of incidents has escalated.

Depends on the hospital that they wanted to work, of some of the hospitals I have been to (for different reasons) I would not want friends and family working at a certain one, I have found that, the skill mix has severely been depleted, staff morale is extremely low, and due to the commencement of 12 hour shifts, continuity of care has suffered, team spirits are low, management has bordering on bullying to ensure staff attend work (even when extremely ill), poor shift pattern, and staff that feel undervalued. I have not worked there for a number of months now, but I continue to keep in touch with former colleagues and it is apparent that

things are only getting worse. However where I work now is totally the opposite I hope the introduction of 12 hour shifts, does not destroy the brilliant working relationship that staff have with each other, patients and the management..... let's hope!!!

I do not believe that the ethics are: Patients First. I think that it is all based on financial incentives and not care for patients.

I love working for TEWV in many ways - the staff are dedicated and generally a great set of folk to work with. My issue (in our locality anyway) would be that most of my colleagues work longer hours that they are employed to do on a regular basis. Family relationships are affected. Also, I think that, in spite of all the talk about lean working, the processes are becoming increasingly more burdensome in many areas, and I would like to see a return to the days when the majority of the job was around patient care and not data collection

The service we give is second to none but to work for TEWV is so demanding. The red tape, spreadsheets, records are endless, and prevents us being able to do our job, with respect to wards our patients. It seems our patients are becoming numbers, targets and we are losing the personal touch.

I would not recommend anyone to work in the NHS.

Compared to similar treatment providers, finances and care resources seem limited, placing increased strain and workload on employees. Morale seems low and stress levels seem high amongst employees.

Answer based on personal low pay bands as the percentage awards go against the low paid and end up being a pay cut, the on call agenda for change being a prime example the high bands received in some cases a large incremental rise, we, band 4 and lower, got almost a 50% cut!

I feel that you're not recognised for the work that you do. Culture of more for less. Process driven and not quality led. Too much corporate rubbish which impacts on clinical time. I feel under pressure and have to set clear boundaries to ensure I have work/home life balance.

I understand that the cuts have hit our service and it is not the fault of TEWV, but the consequence is that our case-loads are too high, and the service focus is on the volume of referrals coming in. These are hard times but the administration and disorder make the job difficult. Two staff who were newly recruited already want to leave. Morale is not good.

I have worked in the health service for 32 years and consider myself a hard worker which my appraisals reflect. However I have never been expected to carry such a large caseload and work at ninety miles an hour. As a result I am planning to take early retirement this year, as I'd rather manage a smaller pension than further risk my health.

In the current climate of austerity measures there is a massive impact upon the front line staff with unrealistic high demands and targets that are not adequately accepted by management above.

Staff are increasingly being asked to work above their scope of responsibility, they are asked to do overtime as there is little bank cover, leading to them becoming tired and irritable. The Trust are intent on changes in some areas which seem to make things worse and staff feel under-appreciated despite all their hard work.

Dependent on the place of work. The above mentioned issues may impede upon the staff

role, the care given and the wellbeing of staff.

High stress levels due to a high amount of staff leaving my workplace, resulting in increased stressors for myself and work colleagues.

I think that staff are put under unacceptable and unreasonable levels of pressure with limited concern for staff welfare.

Lack of funding not enough staff to be able to perform and meet Trust expectancies.

Staff are currently treated like cattle with morale being particularly low.

Unfortunately it is with sad reflection that coming to the end of my own career I see very little positive regard for staffs efforts. Indeed as a husband of a nurse who also works in the Trust I have to witness the emotional fall out of the stress at work she endures and what appears to be little support from her management structure. We are but numbers to quantify performances and are often restricted in the care we want to deliver.

Wouldn't recommend anyone to work in NHS at present.

TEWV has always been an excellent place to work. However not in the service I work for. Staff morale is low, staff are burnt out, and management (apart from one who we will probably lose as she is on secondment) don't seem to care as you never see them and all they do is appear to hide behind emails and their office door. We need a total new management restructure. There are now minimal staff who are expected to complete EVERYTHING even though the service is still very busy and remaining staff still have their workload to do AND get extra to do by management on a weekly basis.

Pressure on the shop floor is continuous yet not recognised by management, alongside incessant bureaucracy that takes clinicians away from client contact.

I thoroughly enjoy my job and get along with the vast majority of my colleagues however the team has some difficult dynamics. There can at times be an awful atmosphere that makes me feel particularly tense and uneasy.

A bullying organisation which does not adhere to its own policies.

Although we're providing excellent care, the pressure on our team is considerable and getting worse. Referrals have increased massively and there are not enough beds resulting in elderly patients being sent far away from family/friends. I've worked here a long time and think morale is at an all-time low.

Depends on work area.

Service becoming more results driven, management only interested in getting the job done and ticking the boxes so they get a pat on the back from senior management, no thought for staff, no work life balance or flexible working, team morale low.

The Trust, actually the NHS in general has adopted a business model which I feel goes against the grain of nursing ethos.

I think there is too much expectation placed on staff, especially in the role of care coordinator in community intervention teams. The increasing number of responsibilities and time spent having to sit at a computer completing ever increasing amounts of documentation (some of it

repetitive) impacts upon clinicians being able to dedicate quality time to clients whose needs we are supposed to be there for and doing the job for. There is over emphasis on targets and tick box culture.

The service I work in make it very difficult to take annual leave or to pre-book leave each year for holidays in advance and are inflexible with the family friendly and flexible working policy due to business needs.

Pressures placed on staff to meet targets is stressful.

Many policies/initiatives, but on the ground staff are poorly-supported in their roles, with an unreliable level of middle/higher management which does not aid staff promptly, leaving them vulnerable.

Stressful, less staff and more service demand.

Feel unsupported as a team by senior management, high caseloads, emphasis on performance targets seem to override what actually happens with patient care.

I don't like how health services are now businesses, we used be able to spend more time with patients, now we spend more time in front of a computer inputting data, not very nurse-like.

Staff too busy and too stressed partly because spend so much time in front of screens.

High stress environment. Too many temporary contracts, not enough job security. Cuts to funding mean there's not enough staff.

Local management is good, however senior Trust management do not look after the staff or understand the concept of person centred care.

Extremely unlikely

I would never recommend my family or friends to work in a service where for the past 2 months (and this is ongoing) you do not know the certainty of the service – i.e. will you have a job, if you do where will you work. As a result of this uncertainty sadly management in the service have been advised not to spend any money - meaning that staff are carrying laptops and materials in shoulder bags rather than trolley cases.

I am due to leave TEWV employment this month with no other job to go to because I no longer find it a suitable place to work.

After being seriously assaulted by a patient whilst on duty I was sacked for having time off got my job back only through help from UNISON and the Trust refused to acknowledge that the senior manager of that team made the wrong decision in sacking me only that she didn’t have all of the necessary information.. which is outright pathetic she had all of the information because I gave it to her on the day.

I prefer not to comment as issues have not been addressed in the past so no reason to mention them in this forum.

Again, for the team, yes, this is a great team. However, I feel very unsupported by the locality managers and above. As well, why is there such a waste of resources for things such as clustering, assistant locality managers etc... Hire a good secretary for a fraction of the cost and put staff back into teams.

Staff shortages resulting from recent reconfiguration of services have made TEWV an intolerably stressful environment to work in. Staff morale is lower than I have known it in the 22 years that I have worked in this organisation.

Some times staff do not feel supported in their roles and in the past the following comment was made by senior staff we need to recruit nurses because they are hard to find but when it comes to health care workers we can pick up the phone and get a bank worker any time.

Workloads are huge and expectations from management are unrealistic. A lot of staff complete work at home at night and at weekends as there is not enough time in the day to get through the work that is expected of you. TEWV have lost their focus, statistics appear more important than the actual patients we provide care for.

TEWV used to be a good place to work, but now staff are treated as robots, less staff, more work. The staff compact is a joke, looks very good on paper! Staff come way down the list of priorities. We have lost so many incredibly good staff because of the inflexibility who do not allow family friendly working, or reducing/increasing hours, because we are never sure whether the service is going to continue (that's the reason we are given). We are not even allowed to book holidays too much in advance!

No support from management in any areas of practice including access to further training and career progression, all posts are ring-fenced for individuals who are seen by management to fit their mould without consideration that they can do the job safely, have the required skills, training experience and background, bullying by management is rife.

Currently the demands far exceed the resources and whilst I recognise this is a national situation I feel that managers are not listening and simply keep changing the systems, i.e. if we work 'more efficiently this will be possible; no it won't, we were working efficiently when demand matched resource or there was a slight difference. Now changing the systems continuously in the hope this will find a way to meet demand actually 'decreases efficiency'. 'You can shuffle the deckchairs all you want, unless you tackle the iceberg the titanic will still sink.'

Changes in the NHS and this Trust in particular have impacted on the response - the continued pressure on performance related number crunching and empty rhetoric about patients being at the heart of all we do doesn't wash anymore.

The wards are becoming more risky to work every day due to staff shortages.

As a Trust we have gone too big and far too stupid - far too many managers making decisions that just are completely unworkable for us minions at the bottom.

Not reflective of TEWV but more so the NHS as a whole. Too much stress and too little reward.

They has not been any support or direction as to how we can manage cases. There is just an ongoing conveyor belt of assessments, little time for planned interventions. It is impossible to envisage how, with such working practices, that we can ever provide appropriate interventions in a timely manner. For example what is the point of undertaking continuous initial assessment if we cannot then follow up with interventions when needed not just when they can be fitted it to our process of continuous assessments.
My day to day experience is that I work with a group of extremely hard working individuals who would always put the patient first. However, purely based on the targets we are expected to hit, and hoops to jump though, and the stress I have seen staff struggle with, I

would not recommend the Trust as a place to work.

Downsizing of community staffing is leading to stressed and over worked frontline staff whilst there are ridiculous overspends elsewhere in the organisation - doctors salaries and Cardea being two examples. I love the work that I do but I am tired now of working over the hours I am contracted to do because there is no other way to get the minimum onto PARIS to ensure that practice remains safe. My family life is definitely suffering and I am considering a career change.

I feel that within this Trust there is no progression and responsibility is being given more and more to support staff. I feel that in if you work hard there is no reward however I find that people that don't put as much effort in are being given extra hours and promotions.

Feel undervalued, despite working to an extremely high standard and coordinating high levels of complex cases.

As above, understaffed, overworked (never finish on time, do work at home) very limited job satisfaction and extremely stressful.

Constant uncertainty about the service and job security, the 'catty' 'school-like' culture among staff - which is definitely bullying, at times (and this not being addressed by management) and constantly being told that you need to do more and what you are already doing is not enough - despite grinding yourself in to the ground with your current case load, and working out of hours to catch up with admin.

Trust is biased against people whom work hard and are reliable. It is driven by HR whom allow staff to have extensive time off and they also employ staff whom should go down the capabilities route. It is all very well for these people having an easy job or not fully completing their role. However their colleagues are left to do their work, man their shifts . TEWV need to get tough on these people and support those whom do their job.

The Trust is far too big. The NHS in general is not a place I would recommend anyone to work.

This Trust do not look after the staff, the service is completely target focused, I know sometimes there is little the Trust can do about this, but Trust led initiatives and targets are sometimes unrealistic, to the ground floor staff, who on the whole work extremely hard trying to look after and care for their patients, It often feels that this Trust likes to instil an atmosphere of fear.

Lack of morale, very under staffed! Not enough nursing staff or admin support.

Would no longer recommend working in health care to anyone. Even if I really disliked them!

Not a very pleasant place to work, managers not nice managers.

Currently being redeployed.

I don't know TEWV as a whole. But based on my experience working in Roseberry Park acute wards I would never recommend anyone to work there! Ever!

ITEM 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: **27th October 2015**

Title: **Monitor Risk Assessment Framework Report**

Lead: **Phil Bellas, Trust Secretary**

Report for: **Decision**

This report includes/supports the following areas:

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

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

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

BOARD OF DIRECTORS

Date of Meeting: **27th October 2015**

Title: **Monitor Risk Assessment Framework Report**

1. INTRODUCTION & PURPOSE

1.1 The purpose of this report is to seek the Board's approval of the Trust's proposed submission to Monitor under the Risk Assessment Framework (RAF) for Quarter 2, 2015/16 (period covering 1st July 2015 to 30th September 2015).

2. BACKGROUND INFORMATION

2.1 The Risk Assessment Framework provides details of the in-year information which the Trust must submit to Monitor, based on its risk ratings.

2.2 As discussed at the Board meeting held on 23rd July 2015 (minute 15/208 refers), Monitor published a revised version of the RAF in August 2015. This document included a change to the regulator's original proposals with the retention of a 2* risk rating ("Level of risk material but stable") for the new Sustainability and Performance Risk Rating.

2.3 The information and declarations supporting the Sustainability and Performance Risk Rating are due for consideration under agenda item 11.

2.4 This report focusses on the Trust's RAF submission with regard to governance including seeking the Board's:

(a) Self certification of two governance statements as follows:

"The Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards."

"The Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework, Table 3) which have not already been reported."

(b) Approval of:

- A declaration on the number of subsidiaries which are consolidated in the financial results submitted.
- Information on Executive team turnover which is used as a potential indicator of quality governance concerns.
- Exception reports prepared in accordance with Table 3 of the RAF.

2.4 The Board is asked to note that, in a letter dated 15th September 2015, Monitor confirmed the Trust's risk ratings for Quarter 1, 2015/16, as submitted i.e:
(a) A Continuity of Service Risk Rating of 3 (as planned).
(b) A "Green" Governance Risk Rating.

2.5 The Trust is required to submit its Quarter 2 Risk Assessment Framework Return by 31st October 2015.

3. KEY ISSUES:

Governance Targets and Indicators and Declarations

3.1 Details of the healthcare targets and indicators, together with Monitor's thresholds and weightings, supporting the assessment of the Trust's Quarter 2 Governance Risk Rating are set out in Annex 1 to this report.

3.2 The scoring of the metrics is based on the information provided in the Performance Dashboard report (see agenda item 12).

3.3 It is considered that the Board is able to sign off both governance declarations for Quarter 2, 2015/16.

Subsidiary Declaration

3.4 It is proposed to advise Monitor that no subsidiaries are consolidated in the financial results submitted as Positive Individualised Proactive Support Ltd has not yet commenced trading.

Quality Governance

3.5 The information required by Monitor on Executive Team turnover is as follows:

Executive Directors	Actual for Quarter ending 30/9/15
Total number of Executive posts on the Board (voting)	5
Number of posts currently vacant	0
Number of posts currently filled by interim appointments	0
Number of resignations in quarter	0
Number of appointments in quarter	0

Exception Report and Other Information to be provided to Monitor

3.7 In accordance with the requirements of the RAF, the Board is asked to approve an exception report, as set out in Annex 2 to this report, with regard to:
(a) The compliance issues raised by the CQC following its inspection of Forensic Learning Disability Services at Roseberry Park in March 2014 and its Trustwide inspection in January 2015.

(b) The appointment of Mr. Hawthorn as the Trust's Senior Independent Director.
(c) The Trust becoming the provider of mental health and learning disability services in York and Selby on 1st October 2015 (a material transaction) and related CQC compliance issues.

4. IMPLICATIONS / RISKS:

4.1 **Quality:** No risks to quality have been identified.

4.2 **Financial:** This issue is covered in the report of the Director of Finance under agenda item 11.

4.3 **Legal and Constitutional:** No legal or constitutional risks have been identified.

4.4 **Equality and Diversity:** There are no equality and diversity risks or implications arising from this report.

4.5 **Other Risks:** No other risks have been identified.

5. CONCLUSIONS

5.1 It is considered that the Trust is compliant with the requirements of the Risk Assessment Framework at Quarter 2, 2015/16.

6. RECOMMENDATIONS

6.1 The Board of Directors is asked to approve the Trust's Quarter 2, 2015/16, Risk Assessment Framework submission to Monitor including:
(a) The signing off of both Governance Statements.
(b) The Information on Executive Team turnover.
(c) The signing off of the declaration that no subsidiaries are consolidated in the financial return.
(d) The exception report set out in Annex 2 to this report.

Phil Bellas,
Trust Secretary

Background Papers:
Risk Assessment Framework (August 2015)

Annex 1

Analysis of Governance Risk Rating, Quarter 2, 2015/16

Component	Threshold	Weighting	Outcome for Quarter 2	Score for Quarter 2
Mental Health Targets -				
▪ Care Programme Approach (CPA) follow up within 7 days of discharge	>95%	1.0	Target achieved	0
▪ Care Programme Approach (CPA) formal review within 12 months	>95%	1.0	Target achieved	0
▪ Minimising delayed transfers of care	<=7.5%	1.0	Target achieved	0
▪ Admissions to inpatient services had access to crisis resolution home treatment teams	>95%	1.0	Target achieved	0
▪ Meeting commitment to serve new psychosis cases by early intervention teams	>95%	1.0	Target achieved	0
▪ Data Completeness: identifiers	>97%	1.0	Target achieved	0
▪ Data Completeness: outcomes	>50%	1.0	Target achieved	0
Compliance with requirements regarding access to healthcare for people with a learning disability.	n/a	1.0	Achieved	-
Risk of, or actual failure, to deliver Commissioner Requested Services	n/a	Report by exception	No	-
Date of last CQC Inspection	n/a	-	January 2015	-
CQC compliance action outstanding (as at time of submission)	n/a	Report by exception	Yes	Exception report to be submitted
CQC enforcement notice within the last 12 months (as at time of submission)	n/a	Report by exception	No	-
CQC enforcement action (including notices) currently in effect (as at time of submission)	n/a	Report by exception	No	-

Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	n/a	Report by exception	Yes	Exception report to be submitted
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	n/a	Report by exception	No	-
Overall rating from CQC at time of submission	n/a	-	Good	-
CQC recommendation to place Trust into special measures (as at date of submission)	n/a	-	No	-
Trust unable to declare ongoing compliance with minimum standards of CQC registration	n/a	Report by exception	No	-
			Total Score	**0.0**

(Note: The Trust's positions on the EIP and IAPT access indicators, introduced in the Risk Assessment Framework 2015, are not due to be reported until Quarters 3 and 4, 2015/16, respectively.)

Annex 2

Draft Exception Report

(1) At Quarter 4, 2014/15 the Trust advised Monitor that it had declared its Forensic Learning Disability services at Roseberry Park, Middlesbrough to be fully compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 following action taken to address compliance issues and "moderate concerns" raised by the Care Quality Commission (CQC) in March 2014.

Since that time the Trust has been awaiting a follow up inspection by the CQC so that the compliance issues and concerns can be formally signed off. The CQC has yet to confirm the arrangements for this re-inspection.

(2) On 11th May 2015 the CQC published its reports on the inspection of the Trust in January 2015.

Whilst the overall rating provided to the Trust was "Good", the CQC issued requirement notices with regard to compliance with regulations 10, 12, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A copy of the Trust's action plan to address the CQC's requirements has been provided to Monitor.

As at the end of Quarter 2, with the exception of an extension to the timescale for one action to Quarter 4 2015/16, all actions have either been completed or are progressing in accordance with plan.

(3) In consultation with the Council of Governors, the Board appointed Mr. Marcus Hawthorn as the Trust's Senior Independent Director with effect from 1st October 2015.

(4) On 1st October 2015 the Trust entered into a contract with the Vale of York CCG to provide mental health and learning disability services in York and Selby.

As this represented a material transaction, the Trust submitted a self-certification, based on the requirements set out in Appendix D to the Risk Assessment Framework, on 29th September 2015.

Monitor is asked to note that there have been no material changes to the key risks set out in the certification in the short time period since the conclusion of the transaction.

Monitor will also be aware that, on 29th September 2015 and prior to the transaction, the Care Quality Commission deregistered Bootham Park Hospital in York.

In response the Trust has put in place arrangements for the delivery of services previously provided on this site including inpatient, outpatient, ECT and Section 136 activities.

The Trust has sought agreement from the CQC to re-register outpatient, ECT and Section 136 activities at the Hospital.

The CQC visited the Hospital on 9th October 2015 in connection with this matter and the Trust has subsequently responded to a number of information requests and submitted a revised action plan in relation to the Section 136 Suite. Further work is also ongoing with regard to outpatient and ECT services.

An update on the above matters will be provided to our Relationship Manager at Monitor during feedback discussions on the Quarter 2 Risk Assessment Framework submission.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

FOR GENERAL RELEASE **ITEM 15**

BOARD OF DIRECTORS

Date of Meeting: **Tuesday 27 October 2015**

Title: **Governance: Quarterly Progress Report on Governance Action Plans**

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

Report for: **Consideration**

This report includes/supports the following areas:

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

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

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

BOARD OF DIRECTORS

Date of Meeting: **Tuesday 27 October 2015**

Title: **Governance: Quarterly Progress Report on Governance Action Plans**

1. PURPOSE OF THE REPORT

1.1 The purpose of this report is to inform the Board of the progress being made in completing the action plans which the Board approved to strengthen the governance arrangements in the Trust.

2. BACKGROUND

2.1 Quality governance arrangements

The Board commissioned Deloitte to undertake a follow-up review of quality governance arrangements, following the first review that Deloitte carried out which was reported to the Trust at the end of August 2013. A follow-up report was reported to the Board in July 2014.

2.2 Independent review of Board governance arrangements

The Board will also recall that it commissioned Deloitte to undertake an independent review of its Board governance arrangements. This report was issued to the Trust on 15 April 2014 and presented to the Board at its meeting in June, along with an agreed response to the recommendations contained in that report. Those recommendations and the Trust's response are also reflected in the action plan attached as Annex 1.

2.3 As agreed at the July 2014 meeting of the Board, the action plan shown as Annex 1 also contains those actions that remain outstanding / in progress from the August 2013 Deloitte report, together with those handful of recommendations / actions that remain outstanding from the Audit North / Allsopp / Parker reports. It also now includes actions outstanding from the work the Board did when reviewing itself in answering "How does the Board know the Trust is working effectively to improve patient care", as agreed at the Board meeting in January 2015. Thus there is now a single consolidated quality governance action plan.

3. KEY ISSUES

3.1 The Board will see that most of the actions in the action plan are on target. No further slippage has occurred.

3.2 The actions completed are shown in green.
Those that are behind schedule are shown in red.

Those that are broadly on track are shown in black.

4. IMPLICATIONS AND RISKS

4.1 **Quality:** The implementation and achievement of the action plan shown as Annex 1 is likely to lead to an increase in the quality of service provided and certainly lead to an increase in assurance about the quality of service provided.

4.2 **Financial:** No further costs identified.

4.3 **Legal & Constitutional:** The implementation of the action plan is likely to strengthen and improve the level of compliance the Trust has in terms of its licence to operate as a Foundation Trust.

4.4 **Equality and Diversity:** No direct equality and diversity implications have been identified.

4.5 **Other Risks:** No other direct implications or risks have been identified.

5. RECOMMENDATION

5.1 The Board is asked to:

- Receive and note the progress report shown as Annex 1.
- Agree that this report and action plan are shared with Monitor through our Monitor Relationship Manager.

Martin Barkley
Chief Executive

ANNEX 1

INDEPENDENT REVIEW OF (BOARD) GOVERNANCE ARRANGEMENTS APRIL 2014: STANDARD ACTION PLAN

PLAN LOCATION/TEAM: BOARD PLAN DEVELOPED BY: CHIEF EXECUTIVE DATE PLAN AGREED: 29 JULY 2014

NO	RECOMMENDATION/FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE	EVIDENCE	PROGRESS UPDATE
3	Consider spending time on team development as part of the forward programme of Board seminars (no end date is assigned and this is an ongoing consideration for 2014/15).	Board members work effectively together.	Arrange team development session/s at Board Seminars.	Chairman/ Trust Sec	By November 2015	Positive feedback/ Board evaluation.	This will be done in November, the first available slot following the appointment of the new Director of Nursing and Governance.
16	Ensure that there are clear channels of communication for lessons learned across localities following the SDG meetings.	Improve quality from effective dissemination of lessons learned.	Publish monthly "lessons learnt" bulletin.	Dir of N&G	January 2015	Bulletins published.	Partial - The bulletin is being revised based on feedback.
18	The Board should seek to further promote and communicate the mechanisms by which service users can provide the Trust with feedback. In addition, it is important that feedback loops are effectively closed, so that service users are clear on what has been done to address concerns raised.	Ensure that feedback from service users is easily received and used to improve quality.	Increase service user group arrangements in AMH.	CE	December 2015	Report on new arrangements.	Review has started in NY. Quotes being obtained to review in D&D and Tees.
			Implement patient experience workplan in	Dir of N&G	Achieve milestones	Assurance reports to	Complete

NO	RECOMMENDATION/FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE	EVIDENCE	PROGRESS UPDATE
			Quality Strategy.			QuAC.	
25	As part of the implementation of the IIC it is important that the Board understands staff concerns regarding data accessibility and usability. This will therefore ensure that the new system is appropriately tailored to enable all services to access and manage their data effectively and efficiently.	Ensure that information is easily accessible and relevant to staff.	Proceed with development of IIC.	Dir of Fin/ Dir of P&P	December 2015	Feedback on use of IIC.	Complete – survey of staff undertaken with satisfactory feedback.

QUALITY GOVERNANCE ARRANGEMENTS: STANDARD ACTION PLAN

PLAN LOCATION/TEAM: BOARD PLAN DEVELOPED BY: CHIEF EXECUTIVE DATE PLAN AGREED: 29 JULY 2014

NO	RECOMMENDATION/FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE	EVIDENCE	PROGRESS UPDATE
2	**August 2013: Recommendation 8** Ensure a combined risk management system is implemented throughout the Trust. This should incorporate complaints, PALS, claims, Risk Registers, Incident Reporting, FOI, PHSO. This will enable robust escalation of issues, reporting, triangulation, hot-spot identification and better "horizon-scanning".	The enhancement of DATIX is a pre-existing key priority in the Trust's Information Strategy. Work on expanding the use of DATIX to incorporate	Design integrated reports, standardising data systems ready for DATIX use and scoping the extended use of the DATIX system.	Dir of N&G	March 2015	Report formats in place. Standardised data system in place.	Complete – Note: Reports are being reviewed as revised in line with staff feedback to ensure optimum effectiveness.
			Expand use of DATIX and configure new modules and train staff in new systems.		June 2015 December 2015	New modules configured. Staff trained.	The configuration of the new modules is complete and the phase of workplace testing and staff training has commenced. Further work is planned to develop the use of the risk management system.
			Complete server infrastructure work.	Dir of Fin	September 2014	Infrastructure in place.	Complete
			Develop PM3 to secure resource.	Dir of Fin/ Dir of N&G	July 2014	PM3 approved.	Complete
3	**August 2013: Recommendation 12** All front-line services must own their own local risk registers and there must be clear escalation to the corporate RR and BAF.	Each ward, community team, etc. will have their own risk log. As there is a new entry, or concerns about an existing log are increased, the Head of	Quality assure Directorate Risk Registers.	Trust Sec/ COO	May 2014	Independent report received.	Complete
			Train Heads of Service.	Trust Sec/ COO	September 2014	Attendance list.	Complete

NO	RECOMMENDATION/FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE	EVIDENCE	PROGRESS UPDATE
		Service will be notified for inclusion in the Directorate Risk Register with all changes to the Directorate Risk Register that occur in the month being reported to the Locality Management and Governance Board.	Update Risk Registers.	Trust Sec/ COO	December 2014	Updated registers received.	To follow from training. This has been delayed to coincide with when this functionality on DATIX goes live to avoid doing things twice in a relatively short period of time.
4	**August 2013: Recommendation 21** The new risk management interface (DATIX, Safeguard, etc.) should be aligned to the IIC to ensure joined up and systematic reporting and escalation routes. (Please also see R8).	Agreed. This will be done as soon as possible.	Plan in place for the data feed from the new risk management interface into the IIC to be available for Trust wide roll-out of the new system.	Dir of Fin	June 2014	Plan exists.	Complete
			PM3 approved and investment of £160k.	Dir of Fin	May 2014	PM3 approved.	Complete
			Join up DATIX with IIC re. risk management interface.	Dir of Fin	March 2016		On schedule
5	**August 2013: Recommendation 30** Increase standardisation at ward level through; the use of governance dashboards, standard agenda items for team meetings and more effective feedback process on patient safety incidents and complaints.	Agreed. Ward performance dashboards are being developed and will be incorporated as a priority into the IIC development.	Develop IIC to produce ward and team dashboards.	Dir of P&P	September 2014	Dashboards available.	Complete
		A statement clearly articulating the expectations of what it means to be a Ward Manager in TEWV is also at the early	A 3P will be undertaken to develop a statement setting out the expectations of ward managers.	COO	March 2014	Statement exists.	Statement completed and disseminated to ward managers. PM3 Project agreed by EMT

NO	RECOMMENDATION/FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE	EVIDENCE	PROGRESS UPDATE
		stages of development from which standard work will develop including standard agendas, etc. Additionally it will also help inform the content of Personal Development Plans for existing Ward Managers and the training programme the Trust should provide for Band 6 inpatient nursing staff to prepare them not only to deputise for the Ward Manager, but also to secure promotion (should they wish to do so).					May 2015.
		This will be accompanied by the development and introduction of standard work, including templates for ward / team meetings setting out standard agenda items, which will include complaints, PALS, Patient Experience feedback, patient incidents and SUIs.	Develop written guidance and templates.	COO	Q2 2015/16	Guidance published.	Complete - the work on standard work has been completed and the daily management approach has been rolled out. The work is now business as usual and the Locality Heads of Nursing are in the process of setting up Ward Managers Forums in each locality and

NO	RECOMMENDATION/FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE	EVIDENCE	PROGRESS UPDATE
							a Trust-wide Forum has been established under the leadership of the Director of Nursing and Governance.
6	**August 2013: Recommendation 31** Ensure that all ward managers have protected time allocated for governance.	All ward managers are "supernumerary" and are not part of the regular shift pattern as part of the planned nurse staffing levels. The ward managers are usually expected to work 9.00 am - 5.00 pm Monday - Friday and one of the rationale for that is to ensure that they do have time to focus on their governance and other management responsibilities. What is considered necessary is to brief ward managers in detail about what is expected of them with regard to their governance responsibilities. In addition standard agenda items for ward meetings will also be developed and issued	Ensure that all ward managers are supernumerary and have protected time for governance.	COO	Q2 2015/16		All ward managers are supernumerary. The actions in Item 5 above will support the aim of providing clear processes for managing time to support governance activities. As noted above, this will be rolled out by end of Q2 2015/16.

NO	RECOMMENDATION/FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE	EVIDENCE	PROGRESS UPDATE
		as part of the work the Trust is doing on being clear about "expectations on a TEWV ward manager" and the development of a model ward.					
7	**August 2013: Recommendation 32** Reinforce standardised governance processes at the level of community teams and ensure that a specific set of early alerts and triggers are used to identify hot-spots. (See Norfolk Community Services Trigger Tool).	Agreed that it is very important that the Trust develops standard processes for community teams which includes early alerts and triggers being used to identify and report hot-spots.	Communication plan developed and agreed. Communication plan implemented September – December.	COO COO	August 2014 December 2014	Plan in place. Plan completed.	Community Team Dashboard was launched late October on IIC. Triggers have been established through the Trust's Risk and Escalation procedure.
8	**August 2013: Recommendation 37** A new electronic reporting interface will provide improved escalation and automated report generation. Local teams should also be able to extract their own reports from both DATIX and the IIC.	This will be implemented as soon as possible. As previously mentioned, the DATIX workstream in the Information Strategy is being brought forward as much as possible. Local teams can already use the IIC to allow them to understand their performance against the Trust Board monthly dashboard Indicators using the "drill down" facility of the IIC. As additional	Produce ward and team dashboard reports from IIC.	Dir of Fin/ Dir of P&P	September 2014 March 2016	Reports available.	Complete Interface between DATIX and IIC to be developed – due March 2016.

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		systems / reports are generated on IIC this facility will be expanded.					
9	**August 2013: Recommendation 39** The Trust (who have dedicated a resource to this prior to our review) should now start demonstrating that they are recruiting for values as well as capability.	The pre-existing project is continuing which has the specific aim of enabling the Trust to test for attitudes / values and applicant literacy and numeracy levels, during key stages of the recruitment process.	Evaluate Phase 1. Evaluate Phase 2.	Dir of HR	July 2014 March 2016	Report to EMT.	Complete - recruiting for values project complete and is being implemented re apt of all frontline staff. However, an additional phase to the project has been added which will complete March 2016.
			Roll-out to all staff recruitment (subject to EMT approval).	Dir of HR	December 2014	Report to EMT.	Started
10	**August 2013: Recommendation 41** The Trust should aim for a 100% compliance rate for mandatory and statutory training of all staff in active employment. The 100% tolerance should also be applied to all bank staff.	The Trust does in fact aim for 100% compliance rate for mandatory and statutory training for all staff in active employment which includes bank workers. For practical purposes the benchmark of 95% is used recognising that 100% will not be possible because of various staff being on long term sick leave, maternity leave or	Develop and put in place arrangements that will ensure the target is met.	CE	September 2014	Target achieved by March 2015.	**Robust discussion has taken place at EMT on the importance of meeting this standard. There are data quality issues therefore teams that attain 95% or more will be green; 88-94% amber; 87% or less will be red. This will facilitate performance**

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		other exceptional extenuating circumstances. The Trust has reached agreement with Trade Union representatives that annual increments under Agenda for Change are conditional on the member of staff completing their mandatory training and having an annual appraisal. This was introduced approximately twelve months ago.					**management of outliers without data quality issues distracting from the need to focus on the 87% or less teams.**
11	**August 2013: Recommendation 42** There should be absolute zero tolerance on staff starting work without local induction.	Local induction is an essential part of starting a new job and the local induction is required to take place on and from Day 1. A quality check on local induction arrangements will be undertaken in Quarter 4 2013 /14. The 2013 /14 Q4 Quarterly Workforce Report to the Board will include a new KPI concerning local	Develop and put in place arrangements that will ensure the target is met	CE	September 2014	Quarterly workforce report shows 95% attainment.	More detailed exception reports in place to easily identify the outliers and address reporting deficiencies – will be further considered at October 2015 Workforce Group.

NO	RECOMMENDATION/FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE	EVIDENCE	PROGRESS UPDATE
		induction taking place on the first day of employment in the Trust.					
12	**July 2014: Recommendations 1 and 5** The Trust develop a communication programme using a range of channels to formally launch and raise awareness of the Quality Strategy.	To ensure a good level of awareness and knowledge of the key elements of the Trust's Quality Strategy.	Develop communication plan. Implement communication plan.	Dir of N&G Dir of N&G/ CE	August 2014 September 2014 to December 2014	Plan agreed by EMT. Plan completed. Staff Survey results.	Complete – staff briefings were carried out and briefing leaflets distributed. Further awareness raising planned for autumn 2015 in line with engaging York and Selby services.
13	**July 2014: Recommendation 12** The Risk Management Policy is reissued across the Trust with facilitated training and guidance to the QuAGs.	Heads of Service have a good understanding on the application of TEWV's Risk Management Policy at Directorate level and below.	Please see No. 3 above.	COO / Trust Sec	December 2014	Attendance list and quality of Directorate Risk Registers.	Postponed to coincide with DATIX enhanced functionality coming on stream.
16	**July 2014: Recommendation 28** The Trust should introduce fully embedded Deputy Directors of Nursing within localities aligned to the Deputy Medical Directors.	Nursing profession has the capacity to contribute to and be accountable for quality governance in each locality.	Review the structure / duties and deployment of Deputy / Assistant Directors of Nursing.	Dir of N&G/ CE	November 2014	Revised arrangement agreed by EMT.	Complete
17	**July 2014: Recommendation 30** The Trust audit the frequency and content of ward meetings to seek assurance in this area.	Effective ward meetings take place regularly.	Issue guidance about ward meetings. Carry out audit – (commission internal	COO COO	August 2014 January 2015	Guidance issued. Audit report available for	Complete - this is now part of the standard work on daily management as part of the Ward Manager Project. To be agreed as part of audit

NO	RECOMMENDATION/FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE	EVIDENCE	PROGRESS UPDATE
			auditors).			consideration	programme.
18	**July 2014: Recommendation 33** Improve quality of (some of) assurance reporting provided to QuAC to better facilitate challenge and discussion e.g. present trend data for some metrics "per bed day" to enable a direct comparison. Consider reducing the frequency of reporting items to QuAC, in particular consider LMGB representatives attending on a rolling basis.	QuAC receives informative assurance reports that clearly demonstrate any assurance issues. Agendas of QuAC are such that they can be effectively transacted within 3 hours.	Review Terms of Reference of QuAC. Establish Information Analyst capacity and capability in N&G Directorate. Review content of assurance reports to ensure they clearly demonstrate any assurance issues.	CE/ Dir of N&G Dir of N&G Dir of N&G	August 2014 March 2015 December 2014	New Terms of Reference. Staff in post. Assurance reports agreed by QuAC.	Complete Complete Complete
20	**Board QGF self-assessment** The quality of actions plans in response to SUIs and complaints to be improved ensuring they are relevant, proportionate and SMART.	Action plans have SMART actions.	Four more workshops to be arranged on action planning.	COO/ Dir of N&G	March 2016	Attendance lists.	In development planning for end of 2015/16.
21	**Audit North 7.1** The Trust should consider ways to overcome geographical barriers and to help ensure that attendance at meetings represents the most efficient use of staff members' time and engages the maximum number of relevant employees. For example, implementing video and telephone conferencing facilities at all Trust sites for use in meetings.	Reduce travel time and costs and improve use of time.	Implement "Reduce travel expenditure" project.	Head of Psych Therap-ies & AHP/CE	March 2016	Expenditure on travel.	**This is very much work in progress.**
22	**Audit North 9.1** Through consideration of the pros	Optimal management arrangements for Tier	Change management arrangements for EIP.	COO	April 2014	Structure in place.	Complete

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	and cons, management should evaluate whether Tier 4 CAMHS and EIP is most effectively managed through alignment with North Yorkshire. Evaluation should involve consultation with, and consideration of the views of, current management teams and staff members responsible for provision of the services.	4 CAMHS.	Tier 4 remains under consideration.	COO	Ongoing	N/A	West Lane (Tier 4) and Tees CYPS will come under a single Head of Service following retirement of present Tier 4 H of S. D & D will have a separate H of S in September 2015.
24	**Board QGF self-assessment** Can we reduce the amount of time it takes staff to report incidents etc. on DATIX?	Improve levels of reporting by reducing the amount of time it takes.	Develop Business Case to secure resource. Change front end of DATIX.	Dir of N&G	March 2014 ~~October 2015~~ December 2015	Business Case approved. New front end operational.	Complete New front end designed and modules reconfigured. Workplace testing and staff training commenced. Delays due to enhancing scope of new DATIX systems, operational processes and improving infrastructure further to staff feedback and baseline data analysis.
25	**Board QGF self-assessment** Further improve and develop performance system with Clinical	Arrangements exist that incentivises individual and team	Develop proposals.	Dir of HR	September 2014	Recommend ations agreed by	Pay & Reward Policy Statement consultation

NO	RECOMMENDATION/FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE	EVIDENCE	PROGRESS UPDATE
	Governance policies.	performance.				EMT	completed and final version agreed May 2015.
26	**Board QGF self-assessment** Lack of "stop the line" methodology.	Reduction of harm.	To develop a "stop the line" methodology for implementation. Implement agreed methodology.	Clinical Director/ KPO CE	July 2014 March 2015		Stop the line methodology has been developed for use by Psychosis Teams and this is being rolled out, along with all other elements of the Model Line.
27	**Board self-assessment** Benchmarking.	To be able to put in perspective the "performance" of TEWV and learn from best in class.	Benchmark reports on: • Use of MH Act • Use of restraint • Medication errors • Use of inpatient beds	Dir of P&P	July 2015	Reports considered by Board.	Complete
30	**Board self-assessment** Improve communication and involvement with patients and develop new ways of understanding the expectations of patients.	The Trust can demonstrate good use of social media, our web site and user and carer networks to improve our understanding of the expectations of users and carers.	New web site. Strengthen AMH user groups. Increased volume of use of Twitter and Facebook.	Dir of Fin Trust Sec Dir of P&P	March 2016 March 2016 March 2016	New web site operational. New networks / groups operational. Numbers.	On track
31	**Board self-assessment** Improve communications regarding programmes of work and systems by explaining why decisions are taken and email protocol.	Staff understand why decisions are made. Appropriate use of	When the Board and EMT make decisions the reason/s for those decisions is clear. Develop new email	Chief Exec Chief	wef April 2015 wef April 2015	Metric to be determined. New email	

NO	RECOMMENDATION/FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE	EVIDENCE	PROGRESS UPDATE
		emails.	protocol that makes it clear when telephone calls or face-to-face dialogue would be better.	Exec		protocol published.	
32	**Board self-assessment** Improve reporting of results of clinical audits and improve clarity on how action plans are developed and implemented.		Reports to be produced by Clinical Directorate. Action plans developed and implemented by Clinical Directorate.	Dir of N&G Dir of N&G	July 2015 July 2015	Reports to QuAC. Action Plans by Clinical Directorate.	Complete – New suites of reports in place.
33	**Board self-assessment** Establish Learning Sets to help spread learning from experience.	Accelerated spread of what works best and support to key staff.	Establish Learning Sets of people with same roles.	Chief Exec	December 2014	Learning Sets in place.	Deferred due to capacity and doubts about feasibility.
34	**Board self-assessment** Rationalise content on Dashboard.	Ensure consistency, coherence and relevance.	"5" S the Dashboards.	Dir of P&P	~~June 2015~~ September 2015	Report to EMT / Board of outcome of "5" S	Complete
35	**Board self-assessment** To improve understanding of Risk Registers, etc.	Directorate Risks are appropriately identified, described and managed.	Training of Heads of Service and equivalent.	Trust Sec	~~Autumn 2015~~ March 2016	Training completed. Content of Risk Registers. Internal Audit Report.	Training will follow roll-out of DATIX.

FOR GENERAL RELEASE ITEM 16

BOARD OF DIRECTORS

Date of Meeting: 27th October 2015

Title: Information Strategy Update 2015/2016 Q1/2

Lead Director: Colin Martin

Report for: Information and approval

This report includes/supports the following areas:

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

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

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

BOARD OF DIRECTORS

Date of Meeting: **27th October 2015**

Title: **Information Strategy Update 2015/2016 Q1/2**

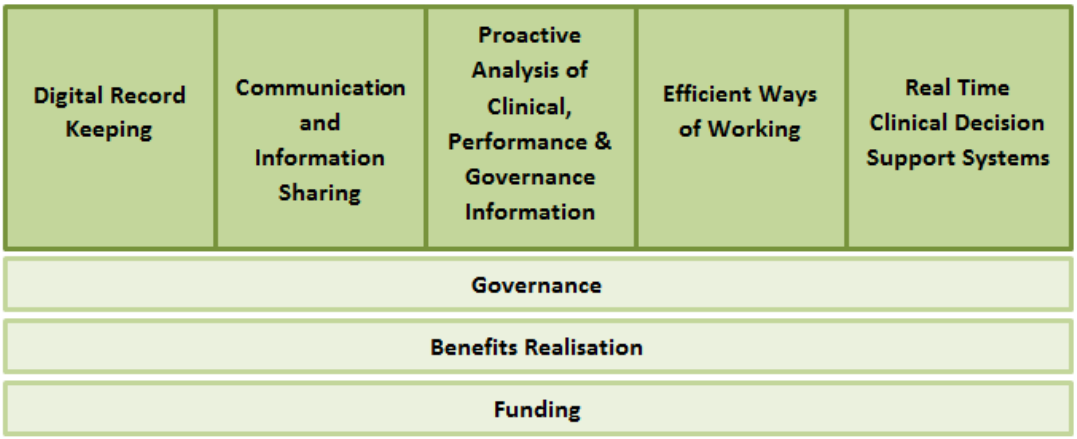
1. INTRODUCTION & PURPOSE

1.1 This report outlines the progress made so far during 2015/16 against the Trust's Information Strategy. The report highlights any business as usual, project developments or notable achievements made across each of the key theme areas identified in the strategy. The format of this report has therefore changed to reflect the new information strategy themes.

2. BACKGROUND INFORMATION

2.1 The Trust's last Information Strategy was developed in 2007 in line with the trust's Business Plan and is now end of life. A refresh of the Information Strategy document to take account of strategic changes at a national and local level in NHS care delivery has been completed following organisational consultation, and will shortly be submitted to EMT for approval.

The new Information Strategy identifies five key themes and is underpinned by several enablers.



2.2 The delivery of the strategy is underpinned by the Information Domain Roadmaps. The current version of the roadmaps focuses upon the two years from 2015 to 2017. Progress against these roadmaps is routinely monitored through the Trust's project management framework and in the Information Domain Groups.

2.3 The current roadmaps have been reviewed to ensure that they align with the change in environment, the NHS information strategy and the Trust priorities over the coming year and are presented in Appendix D – Domain Roadmaps.

3. KEY ISSUES:

3.1 Digital Record Keeping

3.1.1 Clinical digital record keeping

The Paris Programme has been working closely with the Trust CPA project and GP Communications project to agree the principles and the information data sets required to design the new documentation for standard care and CPA. A number of workshops have been held with representation from all specialities. A summary of these workshops and the information data sets were presented to all Service Development Groups in September. Once these have been signed off the design and testing phase can begin.

Work started in September to design and test a means to scan clinical records before carrying out an implementation in the Mental Health Act team in Q4 2015/16. The learning from a focused implementation in a single team will then be used to review how to extend to other clinical areas.

Positive discussion has taken place between Civica and Sunquest (WebIce) to agree the way forward with a path lab solution. This will involve ordering investigations through Paris into WebIce and it will be possible to view all results from all agencies for the identified patient. The results of investigations the Trust has requested will then come back to be stored in Paris. Further details regarding implementation and the potential release date for this will be shared when agreed with the third parties.

3.1.2 Corporate digital record keeping

The KMS project to re-design and store corporate records is ongoing and currently within project timescales. A Trust wide engagement programme has been undertaken to introduce the concept of the new intranet and the links to the electronic records and document management system that will feed the Trust website, intranet and extranet. This approach to communicating with stakeholders across the organisation has proved very successful and will be something utilised by the project going forward to ensure an inclusive approach.

3.2 Communication and Information Sharing

In July the new Trust interim website (phase 1 of the KMS project) was launched which provided a new look and feel for the website and our communication with members of the public and service users and carers. The final platform for the Trust website is undergoing final testing and will be launched during October.

Governance routes have agreed that the new secure NHSmail service for sharing information to organisations using non accredited or insecure email systems can be used. This will allow for sharing of information more quickly and easily with other third party organisations. Before this service can be implemented an amended policy will be submitted for approval.

The trial of ‘Boardpad’ used via iPads for the non-executive directors was successful and full licences have now been purchased to allow the system to continue to be used. Although Boardpad is a standalone system with no connection from the devices to the Trust’s network, the potential to use other devices to connect to the Trust network is part of the Next Generation Devices project.

The Information Service Desk customer portal has been launched on inTouch with a facility to show the real time live performance level of the Information Service Desk. This shows the number of people currently in the queue, the longest current wait experienced that day, % of calls answered in under 3 minutes. This enables users to be aware of the current operating environment of the Service Desk and helps them chose the most efficient way of logging their query. The new Service Desk system gives us the opportunity to introduce centralised asset management and change management and we will be looking to introduce these by the end of the financial year.

3.3 Proactive Analysis of Clinical, Performance & Governance Information

The HoNOSCA/CGAS Dashboard has been completed and is now available in IIC, bringing to a close the PbR Workstream. The development of the Finance, IAPT and Datix work streams continues within expected project timescales. There are now 2884 user accounts for the IIC.

The NHSBN Combined Mental Health Specification for AMH, MHSOP and Specialist Bench Marking has now been submitted; the CAMHS Bench Marking process has also been completed and sent off. This data submission required the production of 304 separate reports by the Information Product team**.**

The new DATIX incidents module went live on 30th September. Incident data will be available to view within the IIC, allowing incident data to be triangulated and analysed alongside data from clinical and staff systems.

3.4 Efficient Ways of Working

Over 400 new computers have recently been rolled out; this was part of the Windows 7 upgrade work, with now over 95% of Trust computers running Windows 7. The remaining 5% will be replaced, upgraded or switched off so that by the 1st October 2015 all Trust computers will be on Windows 7.

Upgrade of the Wi-Fi infrastructure across the organisation is complete; the cost of this has been covered within existing funding and managed though an existing framework agreement. The equipment in place was end of life and so performance of the equipment was becoming an issue and was expensive to replace, the new access points are more powerful and so have an increased coverage range, and are up to 35% cheaper per unit.

Discussions held at the Infrastructure Domain Group regarding Guest Access to WiFi have clarified that the client group for this service will include invited guests, medical students on placement and professional partners. Patients and their visitors will not be in scope. This is because it is not an open access system and thus requires administration of accounts. The effect on the network bandwidth will also need to be assessed. A proposed testing plan has been produced to be undertaken in September and October, with the September intake of Medical students being part of the pilot.

Following a successful test at Durham Prison, TEWV staff working in prisons had access to Paris and ESR from Prison PCs from the end of September. Tailored training sessions have been scheduled to cover network and Paris read only training, as well as ensuring all staff are issued with smartcards.

In June the first upload of sickness data from Health Roster to ESR was implemented. There were a few issues in the first month which were anticipated and so managed within the team, and subsequent runs have been processed without issue. The new interface removes the need for inpatient areas to dual input sickness into both Health Roster and ESR.

The Server Virtualisation element of the Next Generation Devices project has now been delivered by the Infrastructure Product team. This has increased resilience and provided better continuity of service as there is minimal opportunity for failure in the new environment. All of the Microsoft Server 2003 software that was no longer supported and was a risk to the Trust has been upgraded. The next element which is the Virtual Desktop Infrastructure is currently undergoing a competitive procurement process to identify the costs required for this phase of the project, and to identify the most suitable supplier for this development. This process is currently due to complete in November/December and will inform the production of a business case. A virtualised desktop infrastructure allows the Trust to stream bespoke software applications to any device, reducing support and administration overheads.

The Patient Product Team worked closely with the Paris Programme to support the planned implementations of Activity Based Case Notes together with the new functionality to support Segregation and Seclusion. This is less time consuming for users inputting into Paris. A report has shown that there was an increase of activity recorded of 13% in the month of August.

3.5 Real Time Clinical Decision Support Systems

Pathway development under the Paris Programme is planned to commence in Q1 2016/17. As part of building up a common understanding of what Clinical Decision Support Systems could bring to clinical services, interviews are taking place with selected clinicians, service directors and pharmacists in the Trust. This will be used as a basis to review potential requirements and will feed into the development of this theme of the Information Strategy.

3.6 Information Governance

Data Protection Act 1998 - Subject Access requests

During the first quarter of 2015/2016 (April, May, June), the Trust received 319 requests, compared with the same period in 2014/2015, when the Trust received 341 requests. During the second quarter of 2015/2016 (July, August, September), the Trust received 369 requests, compared with the same period in 2014/2015, when the Trust received 375 requests.

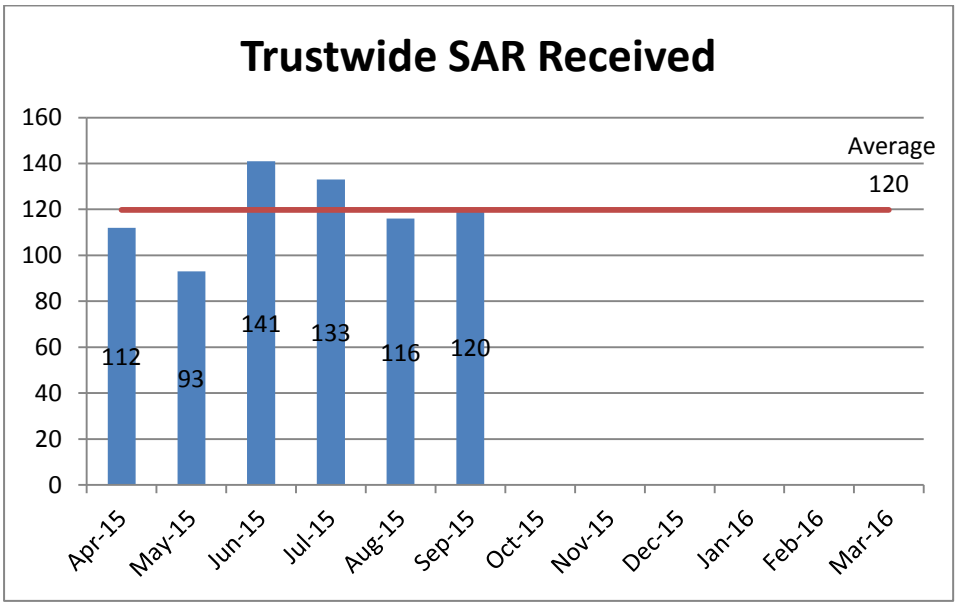
Most notably the number of requests to access staff personal information have increased (this level of detail is not illustrated in the graphs below). During the period April to September 2014, 22 requests to access staff information were received. In

the period April 2015 to September 2015, 37 requests to access staff information were received.

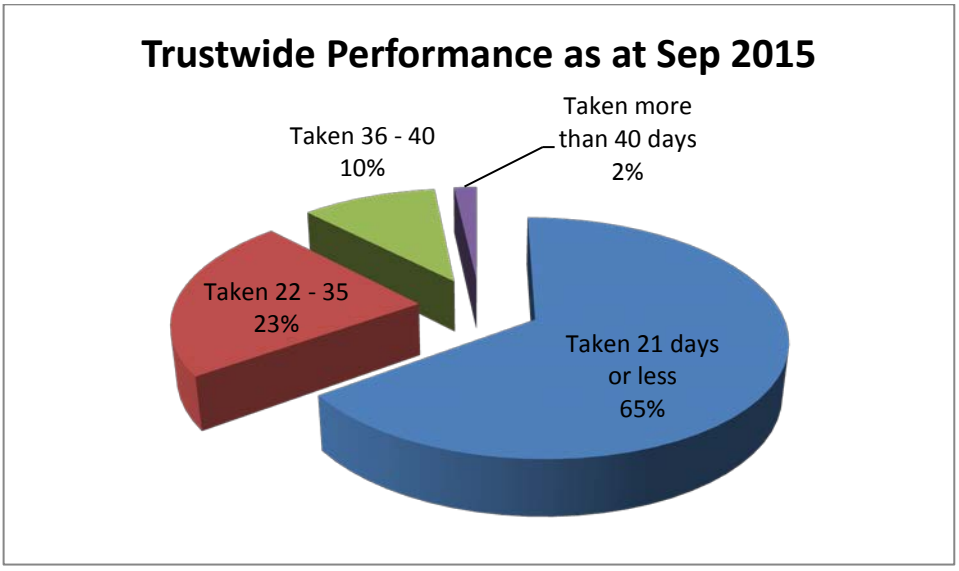
Some requests (2%) have taken longer than the legal deadline of 40 days to process. More than half (65%) of the requests received were processed within the NHS best practice deadline of 21 days.

Subject Access Request administration has been largely centralised to the Records Service office in Durham because of workload pressures on locality Data Protection Officers. Outside of Durham, data protection officers remain in Hartlepool and Easington. From the 1st October, data protection staff in the Durham office will be processing requests for personal information from TUPE'd Vale of York staff. This activity was previously carried out by L&YPFT HR department.

Subject Access Requests Received, April 2015 to September 2015



Compliance with Data Protection Act and best practice deadlines



Information Incidents

The category of incident with the highest number of reported incidents is that of ***information disclosed in error****: letters, correspondence or files sent to the incorrect individual (including photocopy and incorrect printer selection issues).* Incidents of this nature were reported in April, May and June; a total of 25 for these three months combined. This trend is continuing into the second quarter of the year, with 16 incidents of this type recorded in July, 16 in August and 11 in September. The IG department has issued guidance to staff to try to minimise these number of incidents.

Information Governance Toolkit

On the 31st July 2015, the Trust submitted a baseline assessment score of 67% and a target score of 88% for version 13 (2015 to 2016) of the Information Governance Toolkit. An updated score will be submitted by the 31st October 2015. The impact on the toolkit of providing mental health services to York and Selby has been recorded on the mobilisation risk register. At this stage it is unclear how providing these new services may impact on the toolkit score.

Information Commissioner's Office (ICO)

The Trust needs to consider how it will handle its response to requests made under the Re-Use of Public Sector Information Regulations 2015 (RoPSI). A paper is scheduled to go to the Information Strategy & Governance Group in November 2015. RoPSI promotes transparency, proactive disclosure and open data. Improving the re-use of public sector information can increase accountability and create new opportunities for public sector information to be combined into new information products.

3.7 Additional Key Developments or Information Strategy Enablers

The work on rationalisation of Trust mobile phones and 3g/4g dongles has seen 1,800 devices that have not been used for several months suspended (then ceased after one month) – producing a recurring saving in the region of £50k per annum. A process is now in place to suspend unused devices on a monthly basis.

A successful trial was undertaken on the use of a new technology (NetMotion) to allow community staff to work more effectively by enhancing and keeping open network connections using 3g/4g technology. This technology will be considered alongside proposals to improve community productivity.

Following the award from the Nursing Technology Fund that resulted in the 550 devices distributed to nursing staff across the organisation, the Trust is now reporting to NHS England benefits above the base threshold for benefit to cost ratio based on a reduced boot up time for each device. This has been well received by HSCIC who are eager to reinforce the importance of organisations demonstrating the benefits of awards and the impact this may have on future funding allocation. The Digital Input Development project has also been reviewed by NHS England and the Trust is reporting a cost benefit ratio which meets NHS England's expectations. However it is anticipated that further efficiencies could be made from using mobile technology such as this to change ways of working. These developments will act as

enablers for the efficiency drives led by operational services within community services.

4. IMPLICATIONS / RISKS:

4.1 **Quality:** The ongoing management and delivery of the Information Strategy underpins the Trust's priorities.

4.2 **Financial:** The financial implications of each of the schemes are outlined within the project documentation and management approach.

4.3 **Legal and Constitutional:** A number of developments need to be procured through the OJEU framework due to the nature and size of them – this approach is being followed as required.

4.4 **Equality and Diversity:** Equality and Diversity needs are reviewed during project initiation by carrying out an initial Equality and Diversity assessment which is maintained during the project.

4.5 **Other Risks:** none noted

5. RECOMMENDATIONS

5.1 The Board is asked to receive this report on the progress made to date against the delivery of the Information Strategy priorities.

The Board is asked to approve a change from quarterly to biannual reporting as there is now a well-established process in place for monitoring project deliverables. A biannual report would be produced in October to reflect progress from April to September each year and in April to reflect progress from October through to March.

Authors:
Carole Walker-Jones, Head of Information for Product Strategy & Development
Louise Eastham, Head of Information Governance and Records Management

Background Papers:
Appendices:

Appendix A – Information Projects RAG Report (this is provided separately)

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	**PATIENT Domain**						**APPENDIX A**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
2	**Project Title**	**Project Manager/Lead**	**Project Sponsor**	**Project Start Date**	**Project End Date**	**Current Position**	**This months update**												
3	**Paris Programme**	Sue Whitehead	Dr Khouja	Aug-13	Aug-15	Open	MIG passed 3rd party audit and Paris has been upgraded to build 77. GP communication team working with services to agree process. Go Live October 15. Awaiting confirmation from Civica re date for implementation of path labs.Solution to be agreed in Patient domain	Amber/Green	Red	Green	Amber/Green	Amber/Green	Amber/Green						
4	**Telemedicine**	Ian Saunderson	Dr Khouja	Aug-13	Dec-15	Open	Neil Mayfield will seek approval at CLODS in September for the QUaGs to be the approval route to authorise requests for Skype for teleconsultations and for approval of the clinical protocol template for the use of Skype in teleconsultations. If this approval is given, Information department will formalise a procedure, documenting how a clinician gets access to Skype for teleconsultations.	Red	Red	Green	Green	Green	Green						
5																			

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	**INFORMATION Domain**							**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
2	**Project Title**	**Project Manager/Lead**	**Project Sponsor**	**Project Start Date**	**Project End Date**	**Current Position**	**This months update**												
3	**Integrated information Centre** - Phase 1 = Trust Dashboard, Contract Management and Payment by Results	Richard Yaldren	Sharon Pickering	Jan-09	Feb-16	Open	The two outstanding data connections have been created by Advanced. The Datix development has been completed and is now under full testing. The Finance development continues with the manual returns process drawing to an end. The Patient legacy development has started. The performance improvement actions have begun development. The Team and Ward ranking report has been completed.	Green	Green	Green	Green	Green	Amber/Green						

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	**STAFF Domain**							**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
2	**Project Title**	**Project Manager/Lead**	**Project Sponsor**	**Project Start Date**	**Project End Date**	**Current Position**	**This months update**												
3	**e-SIS** - E-Rostering - Self Service - E-Learning	Emma Haimes	Paul Newton	Oct-10	May-15	Complete		Green	Green	Closed	Closed	Closed	Closed						
4																			
5																			

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	**DESKTOP Domain**							**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
2	**Project Title**	**Project Manager/Lead**	**Project Sponsor**	**Project Start Date**	**Project End Date**	**Current Position**													
3	**Patient Access to the Internet** - Managed process for giving patients access to the Internet as part of their care	Jerry Daniel	Chris Stanbury	Jun-11	May-15	Complete	PM4 approved by EMT	Green	Green	Closed	Closed	Closed	Closed						
4	**Knowledge Management** - Procurement - File Management and Records Cleansing - Website improvements - inTouch Stabilisation	Charles Adigo	Elizabeth Moody	Oct-11	Dec-15	Open	Completed the installation of all applications on production environment. Completed regression testing on the newly built production environment. Completed 1st penetration testing cycle and reports have been issued for technical review. 2nd penetration testing cycle will include the full search functionality.	Amber/Red	Amber/Green	Amber/Red	Amber/Red	Amber/Red	Amber/Green						
5	**Service Desk Support Requirements** - Review of services offered by the Information Service Desk	Andrea Brodie	Linda Blenkinsopp	Nov-11	Nov-15	Open	Transfer of project mgt to Andrea Brodie Testing for Change management complete Buidling assest mgt functionality into Assure Developing one access from Work on ESR to AD integration progressing	Green	Green	Green	Green	Amber/Green	Green						
6	**Governance Information Reporting and Management renamed to Quality Assurance and DATIX Expansion (QuAD)**	Nichola Watkins	Elizabeth Moody	Sep-13	Jan-16	Open	Go live is 1st October 2015 and work is on track. Testing and training are compelted. The system configuration is complete and the IIC dashboard is working also.	Green	Amber/Red	Amber/Red	Green	Green	Green						
7	**Smartphones**	Michelle Ferguson	Elizabeth Moody	Mar-14	Apr-15	Closed	The project close down has been submitted	Green	Green	Green	Green	Closed	Closed						
8	**Digital Input Development**	Jo Turner	Elizabeth Moody	Oct-11	Mar-15	Open	All IT deliverables from the project have been met and a PM4 project closure report was issued to EMT in April. The PM4 has been updated to include a full benefits report, inclusive of all 59 teams who provided baseline data. Following the July EMT workshop a KDD was commissioned for options to reconfigure the standard workflow in BigHand. This is still to be presented to EMT. The project manager left the Trust on 11th September with the product having been transitioned to Operations for ongoing support.	Green	Green	Green	Green	Green	Grey						
9	**Patient Experience**	Michelle Ferguson	Elizabeth Moody	Aug-15		Open	Awaiting costs from companies to enable finance information to be added to the procurement form					Green	Amber/Green						

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	**INFRASTRUCTURE Domain**							**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
2	**Project Title**	**Project Manager/Lead**	**Project Sponsor**	**Project Start Date**	**Project End Date**	**Current Position**	**This months update**												
3	**Phones 4 TEWV**	Bob Matheson	David Brown	Nov-11	Mar-15	Closed		Green	Closed	Closed	Closed	Closed	Closed						
4	**EFM Software Review**	Ian Saunderson	David Brown	Feb-14	Nov-15	Open	A draft Business Case for EFM Software has undergone internal review. It will be modified to include additional costs of implementing the electronic Cleanliness Auditing and Reporting system in Hotel Services for technical audits. These costs will be determined in a meeting with the supplier on 19th October and the revised Business Case will go back to the Infrastructure Domain on 20th October.	Green	Red	Green	Green	Green	Amber/Green						
5	**Next Generation Device**	Jerry Daniel	David Brown (phase 1) Elizabeth Moody (phases 2 and 3)	Dec-12	Dec-15	Open	Phase 1 - Server 2003 migrations complete. 1st phase complete. phase 2 underway. All on track Phase 2 - Multiple requests for clarification of pricing model from suppliers. To shortlist by end of 9/15 and enter detailed dialogue 10/15 Phase 3 - Print audit carried out and completed. Awaiting audit report prior to issuing to framwork for procurement.	Amber/Green	Amber/Green	Green	Green	Green	Green						

Information Projects RAG Report

% of Information Strategy on track for delivery i.e. GREEN or AMBER/GREEN
The target is <10% AMBER/RED or RED

DOMAIN	NUMBER OF PROJECTS	ON TRACK
Information	1	1
Patient	2	2
Staff	0	0
Desktop	4	4
Infrastructure	2	2
TOTAL	**9**	**9**

% of Information Strategy projects on track for delivery i.e. GREEN or AMBER/GREEN is 100%

ITEM 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

Date of Meeting: 27th October 2015

Title: Report on the Register of Sealing

Lead: Phil Bellas, Trust Secretary

Report for: Information

This report includes/supports the following areas:

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

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

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

BOARD OF DIRECTORS

Date of Meeting: **27th October 2015**

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

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
254	1/10/15	Tenancy at will deed in relation to NHS Property Service Ltd's properties in the Vale of York	Mr. M. Barkley, Chief Executive Mr. C. Martin, Director of Finance
255	5/10/15	Deed for the transfer of the County Durham and Darlington PCT Charitable Fund	Mr. C. Martin, Director of Finance Mr. P. Bellas, Trust Secretary

4. IMPLICATIONS / RISKS:

4.1 **Quality:** None identified.

4.2 **Financial:** None identified.

4.3 **Legal and Constitutional:** The report supports compliance with Standing Orders.

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

4.5 **Other Risks:** None identified.

5. CONCLUSIONS

5.1 This report supports compliance with Standing Orders.

6. RECOMMENDATIONS

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

Phil Bellas,
Trust Secretary

Background Papers:

The Standing Orders of the Board of Directors (Annex 8 to the Constitution).
Seals Register.