Skill Mix Review Inpatient Mental Health settings and Neighbourhoods

December 2016

Introduction

The report focuses on nurse staffing levels and skill mix across our inpatient wards both mental health and community.

It is written in reference to the National Quality Board (NQB) guidance on safe staffing. In July 2016, The National Quality Board published new guidance: *"Supporting NHS Providers to deliver the right staff, with the right skills, in the right place, at the right time: safe, sustainable and productive staffing".* The publication updated set of expectations for nursing and midwifery care staffing, to help NHS provider boards make local decisions that will support the delivery of high quality care for patients within the available staffing resource. The resource:

- sets out the key principles and tools that provider boards should use to measure and improve their use of staffing resources to ensure safe, sustainable and productive service, including introducing the care hours per patient day (CHPPD) metric;

Care Hours Per Patient Day =	Hours of registered nurses and midwives alongside Hours of healthcare support workers
	Total number of inpatients

- identifies three updated NQB expectations that form a 'triangulated' approach ('Right Staff, Right Skills, Right Place and Time') to staffing decisions; and
- Offers guidance for local providers on using other measures of quality, alongside CHPPD, to understand how staff capacity may affect the quality of care.

This report sets out the Trusts current position and makes recommendations from a professional perspective with regards to staffing establishment. It focusses on reviewing the skill mix, and proposing recommendations to enable the Trust to

support front line staff in delivering safe, high quality clinical care. Whilst the skill mix review is primarily from a nursing perspective reference and consideration has been given to the multi professional teams.

2. Background

Identifying approaches to safe nurse staffing in inpatient mental health settings is a key challenge for health service providers. Recent enquiries (Berwick 2013, Francis 2013, Keogh 2013) have highlighted the role of poor staffing levels in deficits in care leading to adverse outcomes and poor service user experiences. Safe nurse staffing requires that there are sufficient nurses available to meet service user needs, that nurses have the required skills and are organised, managed and led in order to enable them to deliver the highest level of care possible.

On 13th October 2015 NHS England wrote to all Trusts to provide an update on safe staffing and efficiency. The letter recognised the hard work being done by Trusts to get the balance right between keeping services safe and the best use of resources. The letter reminded all trusts that the safe staffing guidance is there as a benchmark but should not replace the judgements of professionals working at the front line. NHS England confirmed their continuing support to trusts to secure both safe staffing and greater efficiency, and further communication in December 2016 from NHS England confirmed that the draft improvement resources for Learning Disabilities and acute inpatient wards (not Mental health inpatient wards) was available. The draft guidance being based on the published document *"Supporting NHS Providers to deliver the right staff, with the right skills, in the right place, at the right time: safe, sustainable and productive staffing", (July 2016)*. It is an ongoing expectation that all NHS Trusts complete a cyclical board level review of safe staffing.

The challenge facing providers of inpatient mental health care is ensuring that the right staffs, with the right skill mix, is available in the right place at the right time. The NQB guidance has formed the framework for the undertaking of this professional Trust wide staffing and skill mix review of all acute inpatient wards.
Currently there is no standardised method to determine safe staffing levels in inpatient mental health settings. However, NHS England published the Mental Health

Staffing Framework. This set out a framework to ensure the right staff ere in the right place at the right time in mental health inpatient settings. This does not at present include a framework for community settings.

Recent years have shown unprecedented position difficulties in recruiting nationally. In November 2016 it was reported that new figures showed that the number of mental health nurses working in the NHS had dropped by a sixth since 2010 (The Guardian, 2016). The Royal College of Nursing (RCN), reported this being concerning stating many mental health patients therefore will not be getting the care they need (Davies, 2016). Whilst it is reported that there are increasing capacity for mental health trainee nurses the rate of nurses qualifying is not matching attrition rates.

There has been much debate as to whether there should be defined staffing ratios in the NHS. It is accepted that at present there is no single ratio or formula that will in all circumstances and across all specialities accurately calculate required numbers. However pilots' sites have been working on formulating against the Care hours: staff hour's formula.

3. Methodology

3.1

This review is intended to identify the evidence base which would help determine the nursing staff requirements in inpatient mental health and community settings and assess how service user, staff, environmental and organisational factors influence nurse staffing requirements in these settings. Employers are responsible for ensuring they have sufficient staff with the right skills to care for their patients

The Hurst tool is often referred to as the evidence based skill mix tool to use for mental health skill mix review. DHCFT have chosen not to adopt the Hurst tool. it is predominantly based on ratio and number management. Whilst recognising these elements as crucial to skill mix review DHCFT wanted to focus on additional key management criteria, of clinically informed decisions making, narrative style analysis, formulation and analysis of patterns and themes.

Staff use professional judgement and scrutiny to triangulate the results of tools with their local knowledge of what is required to achieve better outcomes for their patients.

The methodology used for the skill mix review was as follows:

- Interviewing each Senior Nurse to collect their narrative and confirm team data on:
- Benchmarking team skill data against safe staffing funded resource establishment.
- Reviewing against safer staffing monitoring data.
- Reviewing against workforce metrix including sickness absence staff turnover/use of temporary staffing.
- Interviewing each inpatient Senior Nurse using a standardized approach to collect their narrative, mapping against their team data. The team data included, safe staffing data, serious untoward Incident data, patient experience data and workforce establishment data.
- Leadership capacity
- Datix reportable incidents
- Current skill mix and sustainable planning for the future
- Friends and family feedback
- Ability to support medicines management

The following areas were included within the skill mix review:

Ward	Campus site	Specialty
Enhanced Care Ward	Radbourne Unit	Adult Acute
Ward 33	Radbourne Unit	Adult Acute
Ward 34	Radbourne Unit	Adult Acute
Ward 35	Radbourne Unit	Adult Acute
Ward 36	Radbourne Unit	Adult Acute
Morton Ward	Hartington Unit	Adult Acute
Tansley Ward	Hartington Unit	Adult Acute
Pleasely Ward	Hartington Unit	Adult/Older Acute
Ward 1	London Road	Older Adult Acute

Ward 2	London Road	Older Adult Acute
Cubley Male	Kingsway	Older Adult Organic
Cubley Female	Kingsway	Older Adult Organic
Kedleston Unit	Kingsway	Low Secure
Cherry Tree	Kingsway	Rehabilitation
Audrey house	Kingsway	Rehabilitation
All Recovery teams	Neighborhoods	Recovery (Adult and older adult, including EIP)

The review did not include the following areas:

- Need for current bed numbers and profiles
- Pathway design
- Crisis services
- Perinatal Services
- Childrens

4.0 General Expectations

4.1 Processes

As part of the review consideration has been given to the organizations' wider processes concerning safer staffing.

It is expected that the policies and systems are in place to enable staffing establishments to be met on a shift-by-shift basis. Each inpatient area uses e – rostering and have an escalation processes in place to support staffing decisions on a shift by shift basis.

The Director of Nursing leads on the routine monitoring of shift by shift staffing levels. This is inclusive of temporary staffing solutions.

The routine monitoring includes shift by shift reporting on planned versus actual staffing levels, datix reporting and escalation of actual levels lower than planned; regular review of temporary staff usage and actual fill rate.

Where staffing shortages are identified staffs have an escalation policy and reporting structure through datix in order to provide clarity about the actions needed to mitigate problems identified.

There is a positive culture within operational teams to raise concerns regards staffing. Safe staffing is a standing agenda item on weekly team meetings.

Given the amount of vacancies in band 5 nurses experienced in 2016, escalation of staffing issues have at times been discussed under the framework of the emergency plan.

Recruitment processes are currently paper based and rely on Team/Ward managers identifying vacancies, which includes a risk impact assessment process and then submitting these through an approval to appoint process which requires a hierarchical sign off process. There remains a vulnerability that once a person has been successful at a recruitment event there is still a potentially lengthy period between recruitment and start date if they are a newly qualified member of staff. Work to focus upon engagement of the new employee within this vulnerable time has begun to reduce the risk of ‘drop out’. There are currently developments in progress to move to “track” and electronic flow system to manage recruitment processes. This was a recommendation from the last skill mix review.

4.2 Openness and Transparency

DHCFT clearly display information about the nurses and care staff available on each ward on a shift by shift basis. This information is also shared publically on a shift by shift basis and accessible through DHCFT main website. This information includes displaying information about the range of staff available on a shift by shift basis. A ward level life quality dashboard is currently being developed.

4.3 Considerations to additional duties to direct care

The narrative skill mix review has been mindful to consider in its inquiry that staffing establishments need to allow nursing and care staff to undertake continuous professional development, mentorship, and supervision roles.

The narrative proforma covers these inquiries by team and will form a significant part of the findings and conclusions.

5.0 Findings

Campus North and South Services (Hartington Unit and Radbourne Unit)

5.1 Recruitment and Retention

Vacancy factors in adult acute services have been high throughout 2016. In particular vacancies amongst band 5 nurses has been above forecasted level. There have been periods this year where this has led to risks to operational delivery and resulting in instigation of the Trust emergency plan to monitor and review impacts on quality of care and operational delivery. Staff turnover has been high due to new service development and staff retiring from service.

As indicated in the 2015 skill mix review inpatient areas were awarded a skill uplift in 2014/15 in order to increase, registered nurse numbers on night shifts, and teams have had continued difficulty in recruiting enough band 5 nurses to fulfill the uplift.

However, throughout 2016, Heads of Nursing have adopted a proactive approach to recruitment, through universities', recruitment fairs and social media and band 5 nursing levels are not seeing the same levels of degredation as in other areas. The vacancy factor remains high though and there is a focus upon packages to attract and retain staff where there is a highlighted deficit.

This is evidenced through staffing fill rate reports. In November 2016 all Adult acute inpatient wards were above 90% for registered nurse fill rates for early and late shifts. However 6 out of the 8 adult acute inpatient wards were reporting less than 85% on fill rates for registered nurses on night shifts. This is as a result of not being able to fully recruit to the nights skill uplift.

Vacancies are predominantly being filled with newly qualified nurses and this is creating pressure regards balance of experience on wards, particularly when coupled to the retirement of long standing and experienced members of staff. In addition there have been a number of recruitment drives in recovery teams and CAMHS services which have seen more experienced staff from in-patient areas take up posts in these areas.

Concerns have been raised amongst adult teams regards the balance between preceptorship and experienced staff. Whilst teams have worked collaboratively

across units and services in mapping skill collectively the pressures do still remain given there being an in balance in experience. In an effort to try and map this and without prejudicing the difference between experience and ability the in-patient staff have been identified as those under preceptorship; those within one year of completing preceptorship, and those who have more than one year post preceptorship experience. This is a crude measure and not a reflection of the quality or ability of those staff highlighted; however it does give a sense of the amount of time served experience that the clinical teams have when reviewing skill mix.

5.2 Allowance made in establishment for planned and unplanned leave.

Planned leave is calculated into the funded establishment of costs for planned leave. This includes annual leave, six days mandatory training.

Unplanned leave would be any leave relating to maternity leave, sickness, and urgent domestic or special leave.

Adult teams all raised concern regards bank fill rate. Teams identified that managing unplanned leave could be very difficult, particularly in regards to accessing bank staff at short notice. Accessibility to bank staff over 2016 has become increasingly difficult given a decreasing number of staff available from nurse bank services

Registered nurses with substantive contracts can also carry out bank shifts and it is seen that this is the most reliable way of covering unplanned registered nurse shifts. Whilst this provides consistency and provides quality of care from the perspective that the nurses are permanent team members, it is of concern that nurses are working long hours resulting in potential fatigue and sickness. Sickness rates across Campus Services are currently running at 7.40%, with the Key Performance Indicator being set at 5.04%.

Senior Nurses were all conversant and clear with their responsibilities within the escalation policies regards covering unplanned leave and absence.

All inpatient areas are now utilising electronic rostering and this is now more embedded and familiar to teams. Further work is underway to optimise the use of electronic rostering and the relationship with clinical metrics and measures to

develop increasingly robust safe staffing predictors in the spirit of the HURST tool and bespoke to the needs of acute in-patient mental health care.

5.3 Funded Establishment and Leadership Capacity

All teams reported that there funded staffing establishment was correct against the planned resource. Each Senior Nurse, apart from ECW and Ward 34 reported that their funded establishment was appropriate in relation to Qualified V unqualified staffing ratio for early, late and night shifts.

Each team commented that when fully established they could identify no difficulties' in being able to deliver safe, effective care. However it is of note that increased activity levels in the form of enhanced supportive observations does impact on funded establishment if these increase above one 1:1. It is also recognized throughout the review that the need for these enhanced interventions are often reactive and unplanned.

Each team commented that they felt their leadership resource was manageable and when fully staffed enough to meet the quality priorities such as supervision, appraisal clinical audits and operational performance. However current level of vacancies is significantly impacting on leadership resources as band 6 and 7 nurses are having to undertake and prioritize clinical shifts. This has resulted in underperformance against key clinical quality indicators such including delivery of clinical supervision and clinical audit. There was recognition in budget setting last year that the overall increases in CPD requirement for all professions indicated that the previously agreed uplift of 0.23% (whole time equivalent) was insufficient and new staff are recruited at 0.31% to accommodate the CPD, supervision and training requirements. The uplift does not apply to existing staff currently.

All adult acute senior nurses reported on how the bleep holder duty and requirement to provide service provision to the Section 136 suite greatly impacted on their leadership and funded establishment capacity. This activity is again reactive and unplanned, but of a frequent nature. A commissioner bid was submitted in light of this staffing deficit in response to the findings from the last skill mix review which was submitted at last years commissioning round but unfortunately again not currently

funded in investments in 2017/18 despite being noted in the CQC improvement plan and an outline commitment being made at the quality summit by our lead clinical commissioners.

It is anticipated that this will be reviewed within January 2017 and potentially within the STP framework however in the interim the management of work generated by section 136 attendances, out of hour's bed requests, PICU bed management etc. is managed by the bleep holder. Some pilot posts for flow coordinators to support the administration of these tasks have been identified and are in the recruitment process currently.

All teams viewed the Consultant Psychiatrists as integral to the clinical leadership of their teams. It has been widely recognized that recruiting to SPR vacancies in adult Psychiatry has been very difficult nationally and the market is competitive and limited. There has been a pilot approved to recruit someone with a Non-Medical Prescribing (NMP) qualification into one of these posts in order to begin to facilitate a change in the profile of the in-patient clinical teams. The focus is on the added value of a highly qualified professional with experience and knowledge around complex treatment interventions. This is a reflection of the successful recruitment and integration of an NMP pharmacist within the Dementia rapid response team DRRT pathway.

Each Team values a multi professional skill mix was reporting this benefited patient care. However there were some differing opinions to whether allied Health professionals (e.g. Occupational Therapists, Pharmacists) should constitute part of the actual shift establishment. This has proven difficult to benchmark as other providers who have begun to remap the profile of their clinical teams are either in pilot phase or within a stepped transformational journey which has yet to evaluate. Clearly reviewing skill mix in context of the clinical needs a demographic profile of the community is key an the STP moving forwards has a commitment to this work.

5.4 Infrastructure and Support

All teams had a full time ward administrator and access to a Mental Health Act Administrator and Manager.

All teams felt well supported by estate and facilities services. However Hartington unit voiced there were often delays with environmental works stating the contractual arrangements with Chesterfield Royal Hospital create the delays as Hartington works are never prioritized against the acute trust.

All teams had access to Information Technology and were utilizing electronic performance and reporting systems such as e-rostering.

The adult acute inpatient wards are still in the development phase of PARIS with plans for full PARIS role out scheduled to take place end of January 2017.

The teams welcome the pending changes to meetings and infrastructure and would like to see a greater emphasis on multi-professional working within the meeting structures and more focused task and finish groups. The information flow between groups could also be improved by making more effective use of meetings to decide and execute action plans and then assure on the outcomes.

5.5 Narrative review and emerging themes

Recruitment

The main theme emerging form the skill mix review was the difficulties teams have experienced with the recruitment and retention of registered mental health nurses.

All Acute adult wards with the exception of Pleasely ward are carrying Band 5 nurses vacancies. This is thought to be the largest impact on the team's ability to deliver the highest standards of care. Whilst there have been improvements in filling vacancies Adult acute services continue to have "hotspots" including Ward 34 which currently has 7 wte band 5 nurse vacancies out of a band 5 establishment of 17.5wte band 5 vacancies. This is a combination of leavers, and maternity leave.

All wards report the vacancies have impacted on the leadership capacity. The result of this is weakened performance in clinical and managerial supervision and implementation of assurance processes such as Clinical audit.

In terms of vacancy impact patient care teams are reporting difficulties in providing regular 1:1 named nurse time in line with policy and difficulties in providing meaningful activities on the ward. The wards have allocated areas and resources such as arts and craft materials but they do not necessarily have the staffing

capacity to enable consistent and timely access to this resource. In addition the access to in-patient hub services is varied between sites, notably in the Radbourne where the hub serves as an extension to home treatment intervention. The teams would like to be involved in work to develop out-reach models and recovery college links within the wider community to open up access to wider resources in keeping with the intention to provide 'right staff, right skills, right place and right time'. Relationship management between agencies arose as a key theme from discussion with teams and staff groups. This was in the context of having contemporaneous knowledge of services available and being able to trade resource and skill for mutual benefit.

Each team commented on the their dissatisfaction of having to use the current bank staff provision to fulfill skill mix at times of sickness, vacancy and to provide extra staffing at times of increased activity and enhanced observations.

The core reasons for dissatisfaction were difficulties in being able to fill shifts due to a reduced availability of bank staff and lack of consistency in quality of bank staff, their skills and awareness of mental health.

Each team were clear that bank staff were given a local induction and orientation toward environment and client group but felt this was not enough to ensure staff were adequately confident and trained within mental health skills.

Management of Violence and Aggression

Another emerging theme for all wards has been managing violence and aggression. Teams report casual factors being; alcohol, illegal substance misuse, in particular New Psycho-active Substances (NPS), and the cessation of smoking on inpatient units. The evidence indicates that there is an increased amount of threat and aggression, particularly sexual threat because of the heightened levels of arousal associated with NPS substances.

In regards to NPS both adult acute units are taking proactive steps to educate and support staff in recognizing NPS and also supporting in the care and observations of patients in the event of taking NPS. The Trusts substance misuse service are providing in-reach and support to teams in regards to this. The policy position on

NPS has also been amended and update in light of changes in the legal status and awareness of NPS.

The cessation of smoking on inpatient units has been perceived as more challenging. Teams are reporting increase in smoking and violence related incidents. Teams report feeling powerless in enforcing the cessation and report smoking cessation being a flash point, impacting on skill mix and capacity of teams.

Team members are supported by smoking cessation leads and are adequately trained in advising and prescribing of Nicotine Replacement Therapies (NRT), but continue to report a resistance from patient s to engage with NRT.

Senior Nurses at both Hartington Unit and Radbourne unit continue to voice concerns regards staffing the Section 136 suite using bleep-holders for the existing ward establishment. Since the introduction of the Crisis Concordat Strategy and the cessation of using police cells as a place of safety teams have reported an increase in individuals displaying violent and aggressive behavior. It is reported that it is becoming increasingly difficult and unsafe to staff the 136 suites using this limited and already over utilized resource. There has been some focused review of the support needs of those people being released from prison, particularly those with substance misuse issues as some of our most notable violence and aggression incidents and sec 136 challenges have been linked to people with these demographic factors.

A site visit to Nottingham services on 30/12/16 to review their service provision for managing sec 136 highlighted some interesting differences in both suite and staffing. We visited the Nottingham City resource which serves a population of 320,000 approx. as opposed to derby which has a population of 250,000 approx. The suite has a dedicated staffing resource of 6 Band 6 w.t.e. Nursing staff and 6 band 3 w.t.e. Nursing Assistant staff, equating to two staff on duty per shift over the 24/7 period. The team receives support from a dedicated bed management team which consists of a group of clinicians tasked not only to identify bed resource but also contribute to the proactive management of admission and discharge from the in-patient settings. This is a newly configured service and reflects the FLOW management teams more commonly incepted in Acute Physical healthcare settings locally. Elements of all of these roles fall sit with the bleep holder currently which the in-pateunt team identify

as a significant stressor as they feel the demands of these roles have increased over recent years. As admission rates continue to increase at the rate that they have over recent years, approximately 18% per annum since 2011. It is understandable why it is now timely to review these roles and responsibilities. The opportunity to review section 136 suite staffing, Clinical flow and gatekeeping function would seem opportune over coming months as is the potential to improve focus, efficiency and care. The appointment of a dedicated Area Service Manager for Assessment services (CRHT, Liaison, Criminal justice Liaison Team and MHAHA) may feed into a review of whether this is viable and likely to be supported by commissioners.

There is a current trial of the Broset Violence Checklist (BVC) underway within the ECW unit at Radbourne. This is short item checklist which highlights those who are vulnerable to incidents of violence and aggression. There is an implication for skill mix as the responsiveness to a positive score on BCV checklist relies on being able to convene and MDT review promptly to consider the needs of the person. Further assessment of this is being undertaken in the New year, however early results indicate that there may be some applicable learning across all the acute inpatient areas with some targeted work on MDT structure and accessibility.

Meaningful activity and therapeutic interventions

All adult acute inpatient wards are now adopters of Safewards. All teams have commented positively on the impact this has on the Milieu of the ward. However, without exception, but to varying degrees each have identified a deficit in meaningful and therapeutic activity within the actual ward environments. The reasons for this have been cited as vacancies and in-balances in skill mix.

For example access to Occupational Therapy and Psychology has been identified as difficult for both Radbourne and Hartington unit. There has been triangulation with patient experience concerns here as this has also been raised as a concern. There have been vacancies within Psychology within both units contributing to this. The vacancy at Hartington has recently been recruited to and there is a Psychologist now in post. The Radbourne unit has uplifted the role to Band 8b.

Radbourne and Hartington Unit have reviewed the working models for Occupational Therapy and identified a need for more ward based Occupational Therapy. A pilot will be commencing on ward 35 adopting a model where occupational Therapists work as part of the shift skill mix for early and late shifts.

Hartington and Radbourne Units have both respectively adopted the Purposeful inpatient assessment (PiPa) model which incorporates a multi professional daily review of each patient's purpose for admission.

All teams identified individual registered nurses as having skill sets in a range of therapeutic interventions, including Anxiety management, relaxation management, Psychosocial interventions, CBT, and mindfulness but were unable to produce a skills map against the patient populations needs. Further development of care pathways would link the evidence base for diagnosis to intervention and effective treatment and necessary resource.

In addition to this triangulation of incidents complaints and compliments has contributed to the analysis and found a relationship between skill mix, activity and effectiveness of medicines management. Triangulation has shown that incidents of medicines errors have been higher on wards and where patients report limited information giving on medicines management. A competency Framework for all nurses on medicines management has now commenced. In addition to this a pilot of using Medicines Optimization Therapists is being trialed. It is hoped this will provide enhancement of knowledge and skills within the actual ward establishments and improved information sharing with patients and carers on medicines management.

Senior Nurses also reported that an increase in admissions for people with learning disabilities, autistic spectrum disorders and co-morbidity with mental health disorders has identified some areas for training.. The limited pathways for people with ASD due to local commissioning arrangements have highlighted the need for specific training in order to ensure that people receive the most appropriate care in context of their needs and communication styles. This year a new non CQIN service improvement is that Autism awareness training will be required for all front facing staff, this base level of education or revisiting and refreshing core training will improve the full skill mix of the teams

The single biggest area for development would be to review the gatekeeping and monitoring of people from admission through to discharge. Clear awareness of available local resource when someone experiences a crisis in their personal circumstances and swift access to these services. Strengthening of links into community groups and projects which offer support to people to bolster their resilience. Enablement work to support people who are transitioning between services. This skill set if often held by social workers and the trial of the third clinical professional post on the Early and late shift being held by a social worker, may be a significant service improvement to the clinical skill mix of the wards. tHe Trust does maintain its social work professional forum and a group social worker clinical forum may improve the wider skill set on the wards and additionally reinvigorate the role of a therapeutic social worker in a mental health setting, the knowledge of best interests and mental capacity and enable a more effective use of resources in compiling social circumstances reports which re a great area of difficulty in the ward areas. In addition social workers come with quite advanced safeguarding skills which may unlock some complex health and social care issues and reduce lengths of stay. This will be explored in 2017, with a draft job description and a trial of posts for these shifts.

These are core pieces of work within the STP however the in-patient teams and bridging services need to be beginning to develop the relationships with other parties and providers to map how this will look. There is a request for an enablement service model which builds upon the national recovery work which is showcased by IMROC and links people into social care and tier 3 resources. In addition the inclusion of peer support and carer networks to build recovery resources which are linked to the STP and wider community resources would be of value. Identifying a small team to manage relationships and coordinate between agencies, and bring in the voluntary sector in a much more significant level to the wards, in effect an extension of the in-reach social worker role which has been piloted over the last 12 months would be valuable.

6.0 Findings

Kingsway Campus Older peoples, Rehab and Forensics

6.1 Processes

All areas utilise e- roster; in addition to this wards1 and 2 are piloting an add on to e-roster which captures each patient's level of dependency in order to map against staffing levels and adequacy of these in terms of numbers and skill mix. This has not been on going long enough to draw any safe conclusions, going forwards this could be utilised in the deployment of staff around the Trust to support areas of high clinical activity.

All areas are empowered to increase their staffing, both qualified and unqualified as clinical need dictates; the Kingsway Campus bleep holder carries an overview of the staffing on a shift by shift/24 hour basis and staff are redeployed to meet need as situations can fluctuate quickly.

The senior nurses and Area Service Manager (ASM) have an overview of this in terms of planning and scrutiny of budget.

Older Adults are introducing a 7 week roster to include 5 weeks of days and 2 weeks of nights; this would ensure that all staff work their allocated hours exactly and also get there long weekends etc. Ideally this would be rolled out campus wide.

With the RN staffing deficits in other inpatient areas of the trust there has been an increasing need for RN's to move across to wards and unfamiliar areas; there has been a mixed response to this with understandable anxiety but also a realisation that skills are transferable, band 6 RN's are also working in other areas to support and leading by example on the positives of going to other areas. Further review of this mode of work and how transferable skills can be harnessed further will be reviewed in early 2017.

6.2 Recruitment and Retention

Since the previous skill mix review in September 2015 the Older Adults Tissington Ward has closed due to reduction in clinical need and therefore the immediate bed

requirement, this was after the commencement of the Dementia Rapid Response team being highly effective and reducing the need for unwarranted admissions.

The staffs from Tissington Ward were redeployed to other Older Adult wards which went some way to filling existing vacancies and mitigating the clinical impact of vacancies.

Recruitment is now on a generic advert for all Older adult areas, there are mixed opinions on the success of this; the functional wards would like to continue with an individual recruitment campaign as they have been successful with this previously, however the organic wards have had no applicants for their last 3 cycles of individual recruitment and have been able to recruit through the generic campaign.

There has also been a recent recruitment day which was well attended, interviews were held on the day and Older Adults were successful in 2 appointments.

Cubley Court now have a high number of vacancies, 10 out of a total of 30 RN posts are unfilled, created by RN's retiring and a significant level of staff moving over to the DRRT; although this has rapidly improved the operational capability of the DRRT, the other impact is that the RN's that left were all experienced and knowledgeable clinicians leaving a team of clinicians sometimes lacking in experience and confidence; there is also then a lack of support and development which would be available from experienced staff. This will require a training needs analysis and investment of staff in advanced dementia care and treatment training and a training and improvement plan will be developed by the new Advanced practitioner at Band 7, that has been recruited to improve clinical skills , compliance and competency who is commencing in January 2017.

An uplift in the funded establishment in all trust inpatient areas allowed for 2 RN's on shift at night , this aimed to address safety, effectiveness and consistency across the 24 hour shift pattern; the shortfall in RN's has meant that this has not been achieved in reality of the actual staff deployed and is an area to put into practice in early 2017.

All wards are now recruiting for RGN's and RLD's, these are included in the generic recruitment campaigns, so far there have been no applicants from either discipline. Historically a number of RGNS applied for posts in the service, a revised advert

including an offer of post graduate or degree level training in Dementia care will be advertised to supplement this offer in early 2017

All areas would like to see OT's alongside the RN's and NA's in the numbers and this will be explored in 2017, in new advertisements and supported by the Lead professional for CAMPUS / AHP and the interim Assistant Director of Clinical professional practice.

Rehab and forensics both continue to run their own individual recruitment campaigns with no major deficits in these areas.

The Kingsway Campus and London Road wards have also introduced a development day for the Band 5 nurses, they spend the morning visiting a different area and then reflect on their experiences over lunch, this has been well received and identified as positive and increases confidence and knowledge.

6.3 Allowances made in establishment for planned and unplanned leave.

Planned leave is calculated into the funded establishment of costs for planned leave. This includes annual leave, six days mandatory training.

Unplanned leave would be any leave relating to maternity leave, sickness, and urgent domestic or special leave.

All teams raised concern regards bank fill rate. Teams identified that managing unplanned leave could be very difficult, particularly in regards to accessing bank staff; all teams have a core group of unqualified bank staff that they rely on and book in advance.

All areas report that bank fill rates are declining.

Registered nurses with substantive contracts can also carry out bank shifts and it is seen that this is the most reliable way of covering unplanned registered nurse shifts.

The HR team have received additional investment to spearhead recruitment solutions and support developments in eroster and planning to improve the fill rates.

6.4 Funded Establishment and Leadership Capacity

All teams reported that their funded staffing establishment was correct against the planned resource and appropriate in relation to Qualified and unqualified staffing ratio for early and late shifts.

All areas have had uplift in funding to allow for 2 RN's at night, all areas are working towards this when establishment allows.

Each team commented that they felt their leadership resource was appropriate and when fully staffed enough to meet the quality priorities such as supervision, clinical audits and operational performance; the unfunded bleep holder role did impact on overall capacity of band 6 and 7 nurses; all Senior Nurses reported that HR/SUI investigations impacted heavily on their time and became lengthy processes due to the lack of time to dedicate to them.

The Trust has put forward a business case for 2017, for the SIRI and Complaints team to have two additional Band 7 investigators to support and undertake complex investigations to support the clinical frontline with this service improvement work.

The Kedleston Unit is currently operating above numbers by one (8,8,6) on the staffing for each shift; this had occurred primarily to enable the gentlemen's S17 leave programme to go ahead, there is a formal request for monies to support these numbers, with a consideration of the possibility of a unqualified member of staff whose role would be to support leave and meaningful activity.

The unit also has a Band 6 retiring in December 2016 which gives the opportunity to review the need for 4 x Band 6 RN's which is the current establishment.

6.5 Infrastructure and Support

All teams had a full time ward administrator and access to a Mental Health Act Administrator and Manager.

All teams felt well supported by estate and facilities services.

All teams had access to Information Technology and were utilizing electronic performance and reporting systems such as e-roster and the trust performance dashboard.

All of the Kingsway and London Road wards are established on PARIS, with arising issues being addressed by the PARIS CRG and support team.

6.6 Narrative Review and Emerging Themes

Cubley Court , especially male, have felt a decrease in the ability to complete PADR's and supervision due to the need for Band 6 and 7 Senior Nurses to work in the numbers to compensate for the shortfall in Band 5 RN's , this can then impact on the quality of the patient experience, team satisfaction and staff development and support . Fortunately at this time the Friends and Family feedback does not suggest an increase in concerns and complaints.

Cubley Court, both male and female, have seen an increase in the level of challenging behavior from their patients; since the implementation of DRRT patients admitted to Cubley Court have been in more advanced stages of dementia and require a higher degree of skill to support them, conversely they now have a lower level of skilled and confident RN's since a substantial number transferred to the DRRT. Dementia training has been identified to meet this gap in skills and knowledge.

Cubley Court Male also expressed a wish to have a dedicated discharge nurse as this is often a complex and time consuming business, at this time a band 6 is taking the lead but this distracts from her role providing leadership on the ward. The Nursing and quality team will explore with the Older adults team, the potential to recruit a social worker rather than a nurse to fulfill this role and test and undertake a proof of concept,

Looking to the future recruitment of RMN's will become increasingly more difficult and the Older Adult organic wards are now experiencing the impact of this. Although all areas reported that they are happy with their skill mix when fully established they all perceived that having an RGN(s) presence on the wards would be highly beneficial. This will be explored and any RGN recruited will have a training needs and skills review and will explore the use of Dementia training and or a post graduate certificate in Mental Health.

This ties in with the difficulty recruiting Staff Grade medics and the consideration of having Advanced Nurse Practitioners in the team, this is being considered and a job description and implementation plan will be developed in January 2017.

All areas have expressed a wish for more Nursing Assistants to complete the Medicines Related Duties and an improvement plan for this work will be led by the new Band 7 Advanced nurse- Clinical competency

All areas commented on bleep duties and completing investigations impacting heavily on clinical time and visibility on the ward, suggestions made included having a team dedicated to investigations.

AS discussed previously the older adults team would have access to the Trust has put forward a business case for 2017, for the SIRI and Complaints team to have two additional Band 7 investigators to support and undertake complex investigations to support the clinical frontline with this service improvement work.

All areas spoke highly of their OT input and in some areas refreshing of their OT programme, all areas identified a need to have activities available in the evening and at weekends, 2 wards have established an activity schedule during these hours, devised with the help of the OT's and delivered by the Nursing Assistants.

All areas spoke of the lack of strategy regarding recruitment, especially when planning for known events like retirement. Workforce and OD continue to operate on a paper based system which appears ineffective and cumbersome and the services would like to see improvement in the systems and processes that support them.

There is an appetite for Band 4 assistant practitioners with some Nursing Assistants already completing this training, the Trust are now moving forwards with supporting this training and are considering expressions of interest in non-acute areas for the Associate practitioner role.

All areas are to receive monies in their next financial year budget for a Band 4 post in the establishment, it is then up to the individual areas as to what role they wish this to be.

Specifically the London Road wards reported on their isolation and the wish to be sited on the Kingsway Campus; there is currently a consideration of clinically

standing down and temporary closing Ward 1 due to reduced clinical activity and significant levels of vacancy in bed numbers which could enable redeployment of RN's into hard to fill vacancies, within this consideration of relocating a ward into the Tissington House building; decisions will be reached before the end of the year.

7. Neighborhoods

The core principles of community specialist mental health care are:

- Recovery: working alongside patients to enable them to follow their own recovery path
- Personalisation: meeting the needs of individuals in ways that work best for them
- Co-production and partnerships: delivering services with (rather than for) people with mental health problems
- Collaborative care: working with people as experts in their own mental health
- Promoting social inclusion
- Prevention through public health strategies and early interventions
- Promotion of mental health
- Pathway working: building on the stepped care approach from primary care and viewing mental health services as a system rather than a series of isolated services.

Guidance for commissioners of community specialist mental health services (2013)

Our teams also embrace the need to provide holistic healthcare and ensure that physical and mental health needs are explicitly met.

7.1 Current Situation:

As reported the December quality committee, Item 7: Current waits for mental health care coordinators in the Community, the recovery teams have significant pressure on teams, with 17 % increase in referrals, excessive caseloads

Current establishment (WTE) – see Appendix 1

CQC findings for Neighbourhood teams

Derbyshire Healthcare NHS Foundation Trust

Community-based mental health services for adults of working age - Updated 29 September 2016

We rated community based mental health services for adults of working age as requires improvement because:

- Not all locations where patients were seen and treated had access to emergency equipment.
- Waiting lists for psychological interventions were long, which prevented patients receiving treatment when they needed it.
- Levels of training and appraisal for staff were below the target levels set by the trust.
- Not all areas of buildings were clean and well maintained which impacted negatively on patient comfort, privacy and confidentiality.
- Staff did not routinely participate in clinical audit activities; this meant that the care provided was not being reviewed against agreed standards.

- Staff did not routinely give patients on community treatment orders their S132 rights in line with the Mental Health Act Code of Practice and did not routinely provide patients with information on advocacy services or how to complain. Care plans did not consistently demonstrate patient involvement or a focus on recovery.
- Staff felt that there was a lack of leadership from board level in the organisation and little ongoing guidance was provided on service transformation and the implementation of the Neighbourhood model. Staff did not consistently report that senior managers were visible or accessible.

However:

- Patients and carers were happy with the way that staff worked, describing them as respectful, caring, and responsive.
- There was a range of information leaflets available to patients and carers.
- We saw local examples of good and innovative work practices including equine therapy and initiatives to reduce the stigma of mental health.
- Staff supported patients with physical health, accommodation, employment, recreation and financial needs.

Stability in managers

Of the 8 Neighbourhood managers, 4 are currently temporary/Acting Up.

Stability in Consultant psychiatry

Ask ACDS to add in hers and impact

The overview of safer staffing is captured in monthly staffing levels report. The Service Managers and ASM have an overview of this in terms of planning and scrutiny of budget.

Across the neighbourhoods there is a shortage of 61 CPN's which have had an impact on capacity, patient experience and waiting times in each area? There has been an increase in Band 5 and HCA posts in recent months.

This paper will explore the development of an early warning system to explore when those patient experience concerns become patient safety concerns.

All areas in total have 16% utilised safer staffing monies to increase their staffing, and are encouraged to complete risk assessments via Datix regarding the usage of qualified agency/bank staff as required.

Challenges presented by the current approach to staffing:

- Little planning based on data leading to difficulty in forward planning to meet the challenges of demographic changes.
- Difficulty in succession planning particularly for more specialist therapies
- Multiple 'single points of failure'; namely investing skills in single members of staff which results in service gaps if the person leaves the service.
- Opportunistic approach to accessing educational courses

Consequence:

- Long waits for certain therapies
- Unattractive working environment leading to vacancies
- Career stagnation – poor career opportunities
- Weak application of evidence based practice
- Poorer patient experience

7.2 Understanding need:

National Tariff Payment System (NTPS) care clustering data has been collected monthly since 2012 and has given the trust an understanding of demand by neighbourhood for example:

Neighbourhood	Cluster days	Total contacts	Cluster days Non Psychosis	Total contacts Non psychosis	Cluster days Psychosis	Total contacts Psychosis	Cluster days Organic	Total contacts Organic
X	612102	37602	242957	14837	178348	14796	176324	6373
%	100	100	39	40	29	39	28	17

Further analysis breaks down the data into:

Domains of Complexity:

Domain 1 & 2 interventions would normally be used in conjunction with Domain 3 interventions

<table>
<tr><td>Domain 1: Symptom Recovery
(High Dependency/Complex) Clusters: 6,7,8 15</td><td rowspan="4">Domain 3: Recovery & Resilience
Clusters: 1,2,3,11,12,18,19

Interventions aim to help the patient reengage their self-care and self-management skills and develop supportive networks where this is needed.
Needs are around re-establishing supportive and helpful relationships and the development of recovery and resilience not just in the patient but also in the systems, families and communities around the person.</td></tr>
<tr><td>Needs are very complex or more resistant to change
Intervention requiring specialist skills and tend to be more complex or more resistant to change</td></tr>
<tr><td>Domain 2: Symptom reduction & therapeutic intervention
Clusters: 0,4,5,10,13,14,16,17,21,22.</td></tr>
<tr><td>Needs are more responsive to change.</td></tr>
<tr><td colspan="2">Work will tend to be inter-agency</td></tr>
</table>

Using public health data we plan for future demand based on changes to demography using the model above.

With reference to the NICE guidelines and other evidence, the most appropriate interventions for non-psychotic disorders the skills that need to be available include:

- Cognitive Behavioural Therapy, CBT may be preferred in severe depression
- Dialectical Behaviour Therapy
- Interpersonal therapy (IPT)
- Behavioural couples therapy)
- Group-based cognitive and behavioural interventions
- Behavioural activation (but note that the evidence is less robust than for CBT or IPT
- Intensive Short Term Dynamic Psychotherapy
- Systemic therapy
- Medication Management

For people experiencing psychosis the NICE and other evidence interventions highlight:

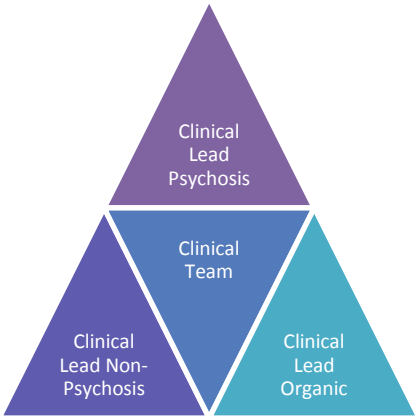
- Psychosocial interventions
- Family /Systemic interventions

- Cognitive Behavioural Therapy for psychosis (CBTp)

7.3 How the skills could be deployed.

Initially the data would suggest that the skills need to be deployed equally for people with non-psychosis disorders and with psychosis disorders.

In order that all service users have access to evidence based care (EBC), care plans and reviews should be supervised by staff with and advanced level of knowledge and skill. In order to address this, whilst acknowledging the capacity of the clinical teams, the plans developed as part of the mental health element of the Sustainability Transformation Plan for Derbyshire, identifies changes to the neighbourhood teams which will see 'Team Leaders' with advanced skills in the relevant clinical skills, for each of the 3 main care domains, non-psychosis, psychosis and organic, take responsibility for the application of EBC in care planning and reviews.



Neighborhood service improvements to be led by the Lead professionals for Neighborhoods working in partnership with Education

1. A full community skills map.
2. All practitioners, LO service
3. All current skills and expressions of interest for an additional training, the development of a psychological skills improvement plan

8. Conclusion and Recommendations

8.1 Summary

The main theme emerging from the skill mix review has been the continuous challenge with filling nurse vacancies and retention. In addition to this the organizational landscape is changing with greater emphasis on system wide working practices; working across therapeutic boundaries and greater emphasis on person centered care rather than symptom led care. These changes to the workforce, organization and patient needs require greater utilization of multi-professional skill sets, meaning we can no longer just rely on uni-professional care models. Given this the skill mix review will make a number of recommendations that will have an impact of the organizations workforce planning and strategy.

This skill mix review does not include Learning Disabilities, Substance Misuse, children's or CAMHS services, it is therefore recommended that a review for these areas will be undertaken in Quarter 4 0f 2016/17, and completed within Quarter 1 of 2017/18.

It is recommended the following actions are considered for implementation:

8.2 North and South Campus

- For the workforce strategy to identify the benefits of including Allied Health Processionals within actual ward establishments (e.g An Occupational Therapist, Psychologist Assistant, Social worker or Pharmacist Technician as third registered professional rostered only for Early and Late shifts
- For the Workforce Strategy to identify how best to utilize Registered General Nurses and Registered Learning Disability nurses within the actual funded establishments and associated training plans
- Review temporary staffing contract offer, including skill set and mental health training provision offered to temporary staff.
- For the Workforce team to consider reviewing the amount of extra hours substantive staff are undertaking in line with safe working hours and time directive and monitor this more actively through the operational structures.

- For each service line to develop a meaningful activities strategy for all inpatient services in line with evidence based care, this should include evenings and weekends.
- A skills mapping exercise to be undertaken in line with evidence based care for each ward identifying each individual with the teams skills, knowledge and competencies. A model template will be designed with Education to develop the teams in undertaking this analysis
- To undertake a skills and safety review to the possibility of being able to deliver physical healthcare interventions such as Intravenous therapies and catheterization in older adult services, to be led by the Nurse Consultant for safety.
- To implement the electronic approval to appoint system ("Track") eliminating the need to rely on paper based sign off systems.
- To resubmit a business case for the staffing of the Section 136 Suites at Hartington and Radbourne Unit and add this commissioning gap to the risk register if failure to invest in services in 2017 contracting round is not achieved. To consider a gatekeeping and flow function as part of staffing service model for Section 136/Pace of safety.
- To undertake a regular care contact review for each ward area to enhance future skill mix reviews.
- To undertake a skill mix review on Crisis services in Quarter 4 of 2016/17

8.3 Kingsway Campus

Although all teams reported that the current planned skill mix with a fully established work force would be adequate, safe and effective they acknowledged that there is a shortfall in RMN's and current recruitment is not adequate to resolve this, there is agreement that RGN's would be beneficial across the campus and in Cubley Court ANP's would be highly beneficial.

There is also a need for a training package in Dementia awareness for both existing staff and obviously those coming into the service.

There was also shared agreement that OT's in the rostered numbers would enhance the patient experience and that an evening and weekend programme of activities would be beneficial.

Kedleston is currently undergoing a review of its establishment and skill mix and it has been identified that there are gaps in meeting the need to support S17 leave, where an RN is not necessarily required; there is also a gap in provision of activity in the evening and weekend but again a programme had been devised, monitoring will occur to ensure delivery.

There continues to be dissatisfaction with the level of support that the Nurse Bank provides, both fill rates and skill level of the staff provided; there is work underway to look at this and different options available.

8.4 Neighborhoods

Conclusion

It is evident from the analysis of the skill mix in Neighborhoods that the main influencing factors are associated with demonstrable increasing demand, coupled in a gap in the traditional workforce model:

- National average referrals to community mental health teams increased by 19% 2011-2015
- Local increase of 16%of clinical referrals in past 12 months
- 5% increase in caseload
- Gap reflected in waiting lists for assessment and care coordination
- 2015 report showed deficit in care coordination of 61 clinicians
- Commissioners have increased resource to deliver 16 clinical posts
- 40 leavers across Neighbourhood services, 18 care coordinator posts
- Waiting lists managed through policy – risks are medium to high
- Innovation without evidence increases risk, therefore all development require tracking and improvement plans to be monitored
- Solutions through innovation and STP, to be explored.

It is therefore recommended full Implementation of the updated STP model with associated focus on a strategic training plan based on addressing the prevalent demand and designed to meet future need.

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Keough, B., (2013). *Review into the Quality and Care and treatment provided by 14 Hospital Trusts in England. Overview Report.* July 2013. NHS England.

National Quality Board (2016). *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe Sustainable and Productive Staffing.* National Quality Board. London. July 2016.

Appendix 1

Amber Valley

Subjective Class	Code	Name	WTEs Funded
PAY	5029	Senior Manager Band 7	0.50
PAY	5236	Nurse band 7	1.50
PAY	5250	Bank nurse band 6	0.00
PAY	5251	Bank nurse band 5	0.00
PAY	5268	Nurse band 6	18.01
PAY	5269	Nurse band 5	9.05
PAY	5354	Occ Therapist band 6	2.00
PAY	5355	Occ Therapist band 5	0.00
PAY	5655	Admin & Clerical: Bank	0.00
PAY	5657	Admin & Clerical band 3	2.98
PAY	5658	Admin & Clerical band 2	0.60
PAY	5672	Healthcare Asst Band 3	2.00
PAY	5762	Staff Vacancy / Turnover	0.00
PAY	5816	Agency Nursing: Band 6	0.00
PAY Total			**36.64**

Erewash Neighbourhood.

Subjective Class	Code	Name	WTEs Funded
PAY	5029	Senior Manager Band 7	0.50
PAY	5236	Nurse band 7	1.50
PAY	5250	Bank nurse band 6	0.00
PAY	5254	Bank nurse band 2	0.00
PAY	5268	Nurse band 6	15.48
PAY	5269	Nurse band 5	4.58
PAY	5354	Occ Therapist band 6	1.60
PAY	5355	Occ Therapist band 5	1.48
PAY	5655	Admin & Clerical: Bank	0.00
PAY	5657	Admin & Clerical band 3	2.30
PAY	5658	Admin & Clerical band 2	1.23
PAY	5672	Healthcare Asst Band 3	3.80
PAY	5762	Staff Vacancy / Turnover	0.00
PAY	5816	Agency Nursing: Band 6	0.00
PAY Total			**32.47**

South Derbyshire and Dales

Subjective Class	Code	Name	WTEs Funded
PAY	5029	Senior Manager Band 7	0.00
PAY	5236	Nurse band 7	1.50
PAY	5250	Bank nurse band 6	0.00
PAY	5268	Nurse band 6	15.58
PAY	5269	Nurse band 5	4.50
PAY	5354	Occ Therapist band 6	2.21
PAY	5355	Occ Therapist band 5	2.00
PAY	5357	Occ Therapist band 3	1.00
PAY	5655	Admin & Clerical: Bank	0.00
PAY	5657	Admin & Clerical band 3	4.42
PAY	5658	Admin & Clerical band 2	1.76
PAY	5672	Healthcare Asst Band 3	3.00
PAY	5762	Staff Vacancy / Turnover	0.00
PAY	5816	Agency Nursing: Band 6	0.00
PAY	5890	Agency Ocuptinl Therapst	0.00
PAY Total			**35.97**

Chesterfield Central

Subjective Class	Code	Name	WTEs Funded
PAY	5029	Senior Manager Band 7	0.00
PAY	5236	Nurse band 7	1.50
PAY	5250	Bank nurse band 6	0.00
PAY	5268	Nurse band 6	15.01
PAY	5269	Nurse band 5	6.35
PAY	5354	Occ Therapist band 6	2.13
PAY	5355	Occ Therapist band 5	1.50
PAY	5655	Admin & Clerical: Bank	0.00
PAY	5657	Admin & Clerical band 3	1.71
PAY	5658	Admin & Clerical band 2	4.51
PAY	5672	Healthcare Asst Band 3	5.70
PAY	5762	Staff Vacancy / Turnover	0.00
PAY	5816	Agency Nursing: Band 6	0.00
PAY	5830	Agency PAMs	0.00
PAY Total			**38.41**

Killamarsh and North Chesterfield

Subjective Class	Code	Name	WTEs Funded
PAY	5029	Senior Manager Band 7	1.00
PAY	5236	Nurse band 7	0.50
PAY	5250	Bank nurse band 6	0.00
PAY	5268	Nurse band 6	13.83
PAY	5269	Nurse band 5	2.80
PAY	5354	Occ Therapist band 6	2.14
PAY	5355	Occ Therapist band 5	1.35
PAY	5657	Admin & Clerical band 3	0.80
PAY	5658	Admin & Clerical band 2	2.63
PAY	5671	Healthcare Asst Band 4	2.00
PAY	5672	Healthcare Asst Band 3	2.40
PAY	5723	Occupational Therapist Bank	0.00
PAY	5762	Staff Vacancy / Turnover	0.00
PAY	5815	Agency Nursing: Band 5	0.00
PAY	5816	Agency Nursing: Band 6	0.00
PAY	5830	Agency PAMs	0.00
PAY Total			**29.45**

High Peak and North Dales

Subjective Class	Code	Name	WTEs Funded
PAY	5029	Senior Manager Band 7	1.40
PAY	5236	Nurse band 7	1.00
PAY	5250	Bank nurse band 6	0.00
PAY	5268	Nurse band 6	14.87
PAY	5269	Nurse band 5	4.63
PAY	5339	Occ Therapist band 7	0.00
PAY	5354	Occ Therapist band 6	3.07
PAY	5639	Admin & Clerical band 5	1.00
PAY	5655	Admin & Clerical: Bank	0.00
PAY	5656	Admin & Clerical band 4	0.00
PAY	5657	Admin & Clerical band 3	2.00
PAY	5658	Admin & Clerical band 2	5.00
PAY	5671	Healthcare Asst Band 4	1.75
PAY	5672	Healthcare Asst Band 3	4.97
PAY	5762	Staff Vacancy / Turnover	0.00
PAY	5816	Agency Nursing: Band 6	0.00
PAY Total			**39.69**

Bolsover and Clay Cross

Subjective Class	Code	Name	WTEs Funded
PAY	5236	Nurse band 7	1.50
PAY	5250	Bank nurse band 6	0.00
PAY	5268	Nurse band 6	13.78
PAY	5269	Nurse band 5	5.00
PAY	5354	Occ Therapist band 6	3.37
PAY	5657	Admin & Clerical band 3	2.00
PAY	5658	Admin & Clerical band 2	2.00
PAY	5672	Healthcare Asst Band 3	4.11
PAY	5762	Staff Vacancy / Turnover	0.00
PAY	5816	Agency Nursing: Band 6	0.00
PAY	5830	Agency PAMs	0.00
PAY Total			**31.76**

Derby City

Subjective Class	Code	Name	WTEs Funded
PAY	5029	Senior Manager Band 7	0.00
PAY	5236	Nurse band 7	4.00
PAY	5251	Bank nurse band 5	0.00
PAY	5254	Bank nurse band 2	0.00
PAY	5268	Nurse band 6	34.10
PAY	5269	Nurse band 5	17.37
PAY	5354	Occ Therapist band 6	3.09
PAY	5355	Occ Therapist band 5	2.63
PAY	5357	Occ Therapist band 3	0.80
PAY	5655	Admin & Clerical: Bank	0.00
PAY	5657	Admin & Clerical band 3	4.05
PAY	5658	Admin & Clerical band 2	4.13
PAY	5672	Healthcare Asst Band 3	9.96
PAY	5673	Healthcare Asst Band 2	0.00
PAY	5762	Staff Vacancy / Turnover	0.00
PAY	5815	Agency Nursing: Band 5	0.00
PAY	5816	Agency Nursing: Band 6	0.00
PAY	5833	Agency Admin & Clerical	0.00
PAY Total			**80.13**