MEETING OF THE BOARD OF DIRECTORS
THURSDAY 25TH MARCH 2021
AT 1.00 P.M.

The meeting will be held via MS Teams

Board Members:
In view of the amount of business to be transacted, Board Members are asked to raise any questions for clarification on matters contained within the reports with the lead Executive Director prior to the meeting.

The 'chat' function on MS teams should not be used during the meeting.

Governor/Public Observation:
Invitations to observe the meeting have been sent to all Governors and posted on social media and the Trust's website. Those responding will be sent instructions to join the event using MS Teams.

If you are observing the meeting please keep your microphone on mute. No questions or statements are allowed.

The timings provided in the agenda are indicative only.

Pre-Meeting Governor Session with the Chairman:
The Chairman has invited all Governors to join her for a pre-meeting question and answer session from **12.00 noon**. This provides an opportunity for them to raise any matters on the reports due for consideration during the meeting.

Joining instructions for the event have been circulated separately.

AGENDA

Standard Items (1.00 pm – 1.20 pm):

1	Apologies.	**Chairman**	**-**
2	Chairman's Introduction.	**Chairman**	**Verbal**
3	To approve the minutes the last ordinary meeting held on 26th January 2021 and the special meeting held on 3rd March 2021.	**-**	**Draft Minutes**
4	To receive any declarations of interest.	**-**	**Verbal**
5	To review the Board Action Log.	**-**	**Report**
6	Chairman's Report.	**Chairman**	**Verbal**

7	Chief Executive's Report.	**CEO**	**Report**
8	BAF Summary.	**TS**	**Report**
9	To note any matters raised by Governors.	**Board**	**Verbal**

Quality Items (1.20 pm – 2.10 pm):

10	To consider the report of the Quality Assurance Committee.	**Committee Chairman (HG)/ DoN&G**	**Report**
11	To receive and note the six monthly 'hard truths' Nurse Staffing Report.	**DoN&G**	**Report**
12	To consider a proposal for staffing establishments.	**DoN&G**	**Report**
13	To consider the report of the Mental Health Legislation Committee.	**Acting Committee Chairman (PH)/ DoN&G**	**Report**

Performance (2.10 pm – 2.30 pm):

14	To consider the monthly Finance Report as at 28th February 2021.	**DoF&I**	**Report**
15	To consider the Performance Dashboard Report as at 28th February 2021.	**DoPCPC**	**Report**
16	To consider the Business Plan Progress Report at Quarter 3, 2020/21.	**DoPCPC**	**Report**

Governance (2.30 pm – 2.35 pm):

17	To approve that from 1st April 2021: (a) Bev Reilly be appointed as the Chairman of the Quality Assurance Committee. (b) Prof. Pali Hungin be appointed as the Chairman of the Mental Health Legislation Committee.	**Chairman**	**Verbal**
18	Report on the use of the Trust Seal.	**CEO**	**Report**

Exclusion of the Public (2.35 pm):

19	**The Chairman to move:** "That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below: *Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.* *Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.* *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.* *Any advice received or information obtained from legal or financial advisers appointed by the Trust or action to be taken in connection with that advice or information.*	**Chairman**	**Verbal**

Miriam Harte
Chairman
19th March 2021

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 26th JANUARY 2021 VIA MICROSOFT TEAMS COMMENCING AT 1.00 PM

Present:
Ms M Harte, Chairman
Mr B Kilmurray, Chief Executive
Dr H Griffiths, Deputy Chairman
Prof P Hungin, Non-Executive Director
Mr J Maddison, Non-Executive Director
Mr P Murphy, Non-Executive Director
Mrs B Reilly, Non-Executive Director
Mrs S Richardson, Non-Executive Director
Mrs R Hill, Chief Operating Officer
Dr A Khouja, Medical Director
Mrs E Moody, Director of Nursing and Governance
Mrs L Romaniak, Director of Finance and Information
Mr D Levy, Director of HR and Organisational Development (non-voting)
Mrs S Pickering, Director of Planning, Commissioning, Performance and Communications (non-voting)

In Attendance:
Mr P Bellas, Trust Secretary
Dr J Boylan, Acting Guardian of Safe Working
Dr N Cook, Higher Trainee
Dr S Dexter-Smith, Director of People & Culture Designate
Mrs A Harrison, Good Governance Institute
Mr D Holden, Good Governance Institute
Ms D Oliver, Deputy Trust Secretary (Corporate)
Mrs K Ord, Deputy Trust Secretary (Membership, Involvement & Engagement)
Mrs S Paxton, Head of Communications
Mr D Williams, Freedom to Speak up Guardian

Observers/Members of the Public
D S Baxter, Public Governor, Redcar & Cleveland
Mrs G Birchwood, Public Governor, York & Selby
Mrs S Brent, Appointed Governor, Sunderland University
Mr J Creer, Public Governor, County Durham
Mrs A Carr, Public Governor, Redcar
Dr A Fairbairn, Appointed Governor, Newcastle University
Mr A Heslop, Public Governor, County Durham
Mrs J Kirkbride, Public Governor, Darlington
Mrs A Lax, Public Governor, Darlington
Dr M Sani, Public Governor, Stockton on Tees
Professor T McGuffog, Public Governor, York
Mr J Preston, Public Governor, Harrogate & Wetherby
Mrs Z Sherry, Public Governor, Hartlepool
Mrs J Wardle, Public Governor, County Durham

One member of the public.

21/01 CHAIRMAN'S INTRODUCTION

The Chairman welcomed members and those in attendance to the first meeting of the year.

On behalf of the Board, the Chairman thanked Mr Levy, Director of Human Resources & OD for his dedication to TEWV over the last twelve years and wished him every happiness in his retirement.

21/02 APOLOGIES

There were no apologies for absence.

21/03 MINUTES

***Agreed** – that the minutes of the last formal meeting held on 24th November 2020 be approved as a correct record and signed by the Chairman, subject to a minor typographical error on page 11, which should have read £2.5m, not £25m.*

21/04 DECLARATIONS OF INTEREST

There were no declarations of interest.

21/05 MATTERS ARISING AND PUBLIC BOARD ACTION LOG

Consideration was given to the Public Board Action Log, together with updates on matters arising from the last meeting.

Further to minute 20/85, regarding seeking a resolution to the issue of Junior Doctors accessing clinical results out of hours, the Director of Finance and Information (DoFI) noted that discussions had taken place with Acute Hospitals in order to gain prompt access for the Doctors in the future and that there would be a slightly different approach adopted for obtaining laboratory results.

21/06 CHAIRMAN'S REPORT

The Chairman noted:

(1) That the governance review being undertaken by the Good Governance Institute was underway with various meetings planned over the next month.
(2) It was intended to reduce the frequency of Board meetings over the coming year.

Part of the rationale for that change was to tailor reporting to meet the needs of the Board particularly for assurance and to allow more focus on implementation and follow through of actions to ensure the intended outcomes had been achieved.

(3) That the Board committee structure was also being reviewed including the establishment of two new Committees, People, Culture & Diversity and Commissioning.

21/07 CHIEF EXECUTIVE'S REPORT

The Board received and noted the Chief Executive's Report which provided an update on the Governance review, Covid-19, staff testing and vaccinations, integrated care system (ICS), the Making a Difference Awards and the introduction of the Carers Charter.

Arising from the report members welcomed:

(1) The positive take up by staff of the Covid vaccination.
It was noted that lateral flow testing for staff, which had been a phased roll out from November 2020, had revealed low numbers of positive results.
(2) Plans for a future Board Seminar on developments around the ICS, implications for the Trust and its partnerships, particularly around the aspiration to be a "Great Partner".
(3) Recruitment plans for more therapy posts, including clinical psychologists and practitioners.
(4) The Carers Charter and the clear messages it portrayed on the one sided statement. It was evident that working together with carers would improve relationships and communication whilst also pointing them in the right direction if the services did not meet their expectations.
The Director of Nursing & Governance (DoNG) added that the Charter, not only set out the Trust's commitment to carers but also provided a mechanism for how the Trust could be held to account and would also provide an element of triangulation for assurance purposes.
(5) The Chief Operating Officer briefed members on developments following concerns raised about the Crisis Team in Durham and Darlington.

It was noted that:

(i) Meetings had taken place with Staff Side representatives with some staff moved to alternative roles.
(ii) Communication through two staff engagement sessions had been well attended.
(iii) It was important that issues within the team and the leadership be dealt with in a timely manner in order to ensure there was no impact on service users and carers and the quality of care provided.

(6) The Chief Executive provided an update on the recent inspection of adult mental health wards in Middlesbrough, Darlington and Scarborough.

It was noted that:

(a) The focus of the visits had been on clinical risk management and risk assessment processes and some serious concerns had been raised about

the robustness of systems, staff understanding of processes and how the Trust learns from mistakes.

(b) The Trust was required to provide a response to the CQC by 27th January 2021.

Agreed: *that the Carers Charter be approved*.

21/08 BOARD ASSURANCE FRAMEWORK (BAF) SUMMARY

The Board received the BAF summary as an aide memoir for consideration of the Trust's risks during the discussions at the meeting.

21/09 MATTERS RAISED BY GOVERNORS

The Chairman highlighted that the following areas had been raised by Governors in discussions prior to the meeting:

(i) Concerns around the Crisis Team in Durham & Darlington.
(ii) Risk management and assessment (the issue picked up by the CQC following the recent inspection).
(iii) Freedom to Speak up Guardian reporting.

21/10 TRUST STRATEGIC FRAMEWORK

Board members received the Trust Strategic Framework and the timescales for the production of the Business Plan 2021/22-2024.

It was highlighted that:

(1) The process for the production of the Business Plan would include the next phase of the Big Conversation where the five key areas of focus would be considered, to ask "what was wrong, strong or missing?".
(2) There would also be a Governor Business Planning workshop held on 4th February 2021, where there would be encouragement to take part in the Big Conversation on line.
(3) The final draft of the Business Plan would be submitted to the 25th March 2021 Board meeting for final approval.

The Chief Executive thanked everyone that had participated in the development of the Strategic Framework, which had taken place over the last six to seven months and had demonstrated the level of energy and commitment to the direction of travel for the Trust.

Board members queried:

(i) The level of service user and carer involvement in the development of the five key areas of the Business Plan.

On this matter it was noted that letters had been sent to service users and carers and any feedback or comments would be taken into consideration. Members and Governors would also be included to ensure their input was taken on board.

(ii) Now that there was a sense of vision for the Trust, how the new Strategic Direction would be implemented?

In response, it was noted that Special Interest Groups had been set up to work on the five key areas that would take this forward to put in place the foundations over the next twenty four months. Each of the five areas had an Executive lead, with a range of staff, service users and carers to concentrate on the specifics.
Progress would be monitored through the business planning route to check on whether the desired outcomes had been achieved, in the first six months.

(iii) The risk around staff potentially not all living and breathing the values and how any assurances might be fed back to Board members.

The Chief Executive agreed that it was tricky to assign a metric for culture; however the approach to embedding the values was being considered through the SIG on "A great place to work".

Members felt that:

(a) There was a clear role for senior leaders to speak up when things hadn't gone well and ask whether improvements could have been made – "to call it out and call it in". Once senior leaders were seen to behave differently that would set the tone for staff to follow.

(b) The introduction of the People & Culture Committee would be a good route for the governance around staff culture.

Agreed:

(i) ***That the Strategic Framework, be approved.***
(ii) ***That the next steps for production of the Business Plan 2021/22-23/24 be noted.***
(iii) ***That the final draft Business Plan be submitted to the March 2021 Board meeting for approval.***

21/11 FREEDOM TO SPEAK UP GUARDIAN

The Committee received and noted the update report of the Freedom to Speak up Guardian.

The key highlights were:

(1) Changes over the last six months included local, regional and national issues and reflections about Covid-19 together with data relating to the numbers and types of referrals.
(2) Up to December 2020 there had been a decrease in the number of concerns raised, compared to the previous reporting period. There had been some Covid related enquiries which had been signposted to operations.
The Chief Executive stated the importance of triangulating the reduction in numbers of concerns over the last quarter, together with the increase in the number of incidents of whistle blowing to the CQC.

It was noted that this mirrored experiences of other Trusts in the region.

The Chairman noted that there had been some big challenges over the last six to nine months; however on a positive note it was good to see more agile and nimble solutions being provided to issues, rather than large investigations.

(3) The number of Dignity at Work Champions had been increased.
(4) Plans were underway in the review of the management of freedom to speak up issues.
(5) Two webinars had been held for staff following the external investigation into concerns in Forensic services.

Non-Executive Directors noted that they had been well sighted on the reviews undertaken in Forensics with regular briefings from the Chief Operating Officer and Director of Operations to the Quality Assurance Committee as well as meetings held outside formal meetings. It was recognised that staff had been through some challenging times, however it was now time to make progress around the action plan and move forward to ensure the teams were delivering quality care.

In response to a question about allegations of bullying and the specific criteria around that, it was pointed out that issues of cultural bullying could be dealt with by the Freedom to Speak up Guardian. Any specific reports of direct bullying would be passed to the Chief Operating Officer, where a manager would be allocated to investigate the allegations through the Trust grievance procedures.

21/12 GUARDIAN OF SAFE WORKING

Board members received the quarterly update report on the Guardian of Safe Working.

In introducing the report, it was highlighted that:

(1) Exception reporting had mainly reflected some variation in the work on non-resident rotas and a new process had been implemented for this which was under review.
(2) Assurance was provided that there was extensive engagement with Junior Doctors in the planning and implementation of rota changes and recording activity.

(3) Robust processes were in place for ongoing scrutiny and review of work schedules to provide assurance on safe working environments.
(4) Progress had been made on the two reported issues of concern to the Board, at its meeting held in November 2020 (minutes 20/85 (6) (i) and (ii) refer).

(i) For the sites at Lanchester Road and Scarborough the appropriate resources had been ordered for the on call accommodation. The time scales for this work would be dependent on the procurement process for the necessary beds and furniture.
(ii) Access to clinical results out of hours. The licenses held with the Acute Trust's had been a dependant factor for "accessing webice". The IT department was working with acute providers to establish a model whereby there could be early identification of rotation for Doctors in order to obtain the necessary licences in a more timely way.

In addition to the report, it was highlighted that:

(a) Dr Jenny Forge (Consultant Psychiatrist in CAMHS) had been appointed as the Champion of Less than Full Time Working for Junior Doctors and this new post would also provide a deputising role for the Guardian of Safe Working.
(b) There had been some concerns raised by senior Registrars and middle tier Doctors regarding pressure to attend the CAS suite to see S.136 patients within the three hour time period. Discussions were ongoing with the Medical Director and the Acute Care Forum.
This was a recognised as an ongoing issue that had also been raised at the Mental Health Legislation Committee and an update would be reported back to its April 2021 meeting.

In response to a query around how the matter would be resolved, it was acknowledged that there were recognised complications trying to balance the desire to resolve an acute situation quickly, within the three hour timescale, against the clinical practice and the need to undertake the necessary assessments.

21/13 QUALITY ASSURANCE COMMITTEE

The Board received an update report on the business discussed by the Quality Assurance Committee (QuAC) including:

(1) The key issues considered at its meeting held on 5th December 2020.
(2) The impact of the second wave of the pandemic on capacity and demand, and the effects on staff health and wellbeing.
(3) The improved, newly formatted locality report, which Teesside had been piloting for two months. The report had been well received and the Director of Operations for the locality had fed back that the information was providing the locality with a more detailed insight into any issues around quality or safety that might be a cause for concern.

The Director of Nursing & Governance added that once the pilot was extended to the remaining three localities, (North Yorkshire & York, Durham & Darlington and Forensics) there would be a clearer line of sight of issues and key concerns leading to a reduction in the corporate reports to QuAC.

(4) The new Trust wide Quality and Learning report had also been well received by members providing a much greater emphasis on analysis with the use of SPC charts, which would hopefully enable better focus and assurance.

(5) There were no significant matters to raise to the Board.

21/14 LEARNING FROM DEATHS QUARTER 3

The Board received and noted the Learning from Deaths report for Quarter 3.

The key issues highlighted from the report were:

(1) That work was ongoing to refine the approach to identifying, categorising and investigating deaths in line with national guidance.

(2) Work continued to improve the mortality and serious incident review processes to allow maximum learning.

(3) Unexpected deaths as a result of patient safety incidents continued to be reviewed.

Following questions from members it was noted that:

(i) The group set up to look at learning from deaths with regional partners had been paused due to the pandemic; however colleagues had remained in touch via Teams to discuss any learning from deaths across the region. An appointment had recently been made to take forward the work of the Mental Health Chief Executive group across North East and Cumbria.

(ii) Being able to provide assurance to the Board around learning from deaths, would be from building in trust wide learning, re-visiting the measures in place to check if the desired outcome had been achieved, taking on board soft intelligence and building in some metrics to the locality reporting in order to be able to have an active line of sight. The Director of Nursing & Governance undertook to reflect on this matter.

21/15 MENTAL HEALTH LEGISLATION COMMITTEE

The Board received an update report on the business discussed by the Mental Health Legislation Committee (MHLC), including the key issues considered at its meeting held on 21st January 2021.

The following matters were raised:

(1) The consultation period on reforms to the Mental Health Act arising from the Simon Wesley report had a closing date of 21st April 2021. Governors, experts by experience and other representatives would be included in the consultation process.

(2) There would be improvements made to tightening up the processes around the completion of Section 17 forms.
(3) There had been some issues raised from audits of wards at Roseberry Park Hospital where there were gaps in patients being provided with the correct information about their rights.
(4) There were no significant matters to escalate to the Board.

21/16 PERFORMANCE DASHBOARD

The Committee received the Board Performance Dashboard report as at 31st December 2020.

The key issues highlighted were:

(1) The 2020/21 Performance Dashboard had first reported to the Board in September 2020, which replaced the interim Dashboard that had been provided since the start of the pandemic.
(2) The Board Performance Dashboard had then undergone significant development to include Statistical Process Control (SPC) charts and a number of the measures revised to be more meaningful.
(3) The feedback from the Board and NHSE/I had been extremely positive.
(4) The proposal that the 2020/2021 Board Performance Dashboard measures should be carried forward into 2021/2022. This was to allow for more time and capacity to develop an integrated approach linked with the Governance Review and the new Strategic Framework.
(5) The recommendation to note that there had been analysis and the relevant actions progressed in Durham and Darlington in relation to the percentage of patients starting treatment within six weeks of an external referral (TD02).
(6) To note the measures that provided positive assurance around:
Percentage of patients seen within four weeks for a first appointment following an external referral (TD01),
The number of patients occupying a bed with a length of stay from admission <90 days (AMG and MHSOP A&T wards.

The Chairman queried why all the current Dashboard measures should be carried into the new year given our new Strategic Framework and expected significant changes to Business Planning.

The Chief Executive advised that it had undoubtedly been an unusual year because of the pandemic, as typically at this point of the Board cycle in January there would have been discussions around the Key Performance Indicators and the plans to review the overall scorecard.
He advised that rolling forward the Board Performance Dashboard measures, with a view to going back to them in a reasonable time would provide an opportunity to consider what should be included in the integrated report.

Non-Executive Directors suggested that it would be helpful for a report to be written explaining and outlining the process for the production of an Integrated

approach to be submitted to the 9th March 2021 Resources Committee. This was agreed.

Action: S Pickering

21/17 FINANCE REPORT

The Committee received the Finance Report for the period 1 April 2020 to 31st December 2020.

The key highlights from the report were:

(1) The national financial arrangements that had been in operation during 2020/21, as a consequence of the pandemic.
(2) The Trust was currently ahead of the revised NHSEI plan by £6,426k with a surplus of £7,938k.
(3) The Senior Leadership Group had undertaken some detailed work to rapidly progress a number of key programmes to improve waiting lists (progressed via the Mental Health Partnership Board), staffing and IT equipment for remote working.
(4) Taking into account performance at the end of December 2020 and a review of run rates, the statement of financial position, Covid and forecasted costs the 'probable case' forecast was £4,012k ahead of the revised required position of £602k surplus, i.e. an outturn surplus of £4,614k.
(5) CRES identified for the financial year was behind plan. Any delays in delivery were being mitigated by non-recurrent underspends.

Non-Executive Directors queried the future for CRES savings, which had been behind plan for around three years.

The Director of Finance and Information (DoFI) explained that:

(i) The newly created Financial Sustainability Board would be looking at the underlying financial issues and challenges, surpluses, deficits and opportunities to improve value for money.
(ii) The national picture would also need to be considered and any efficiencies driven by the Centre that the NHS would need achieved.
(iii) CRES had been raised at the 19th January 2021 Resources Committee and there had been recognition that other priorities had overtaken CRES, however it would be picked up in the coming months.

21/18 GENDER PAY GAP

The Board received the Gender Pay Gap report.

In introducing the report it was highlighted that:

(1) The Trust faced a legal obligation to publish the information around the gap in gender pay.
(2) The latest TEWV report had revealed that the gap between the average hourly pay of all male and female employees, as at 31st March 2020 had reduced

compared to the previous year. It had also been at its lowest since recording began in 2017.

(3) There had been a slight increase in the proportion of female employees employed by the Trust.

(4) Work was planned to try to reduce the gap further.

It was explained that this was most likely due to the lower proportion of males appointed in support worker roles, (ie. Health Care Assistants) at 18%, whereas in other MH Trusts it was around 22%.
It was interesting to note that Merseyside Trust had a zero gender pay gap.

(7) The information had been due for publication in October 2020, however was delayed due to the pandemic.

(8) The next report of the Gender Pay Gap would be submitted to Board in the autumn 2021.

Board members queried:

(i) Whether there was any knowledge around the data for this year, since the information was now a year old.
It was advised that the gender pay gap data was not known for the current year, however it was anticipated that the information might reveal a slight repeated increase in the number of females appointed to senior posts.

(ii) Why the Trust seemed to fare worse than other mental health Trusts.

Agreed:

That the Gender Pay Gap Report be approved for publication by 30th March 2021.

Action: S Dexter-Smith

21/19 USE OF THE TRUST SEAL

The Board received and noted a report on the use of the Trust's seal in accordance with Standing Orders.

21/20 DATE OF NEXT MEETING

It was noted that the next meeting of the Board of Directors would be 25th March 2021.

21/21 CONFIDENTIAL MOTION

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

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

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

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

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 4.05pm.

Miriam Harte
Chairman
25th March 2021

MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS HELD ON 3rd MARCH 2021 VIA MICROSOFT TEAMS COMMENCING AT 3.30 PM

Present:
Ms M Harte, Chairman
Mr B Kilmurray, Chief Executive
Dr H Griffiths, Deputy Chairman
Prof P Hungin, Non-Executive Director
Mr J Maddison, Non-Executive Director
Mr P Murphy, Non-Executive Director
Mrs B Reilly, Non-Executive Director
Mrs S Richardson, Senior Independent Director
Mrs R Hill, Chief Operating Officer
Dr A Khouja, Medical Director
Mrs E Moody, Director of Nursing and Governance
Mrs L Romaniak, Director of Finance and Information
Dr S Dexter-Smith, Director of People & Culture (non-voting)
Mrs S Pickering, Director of Planning, Commissioning, Performance and Communications (non-voting)

In Attendance:
Mr P Bellas, Trust Secretary
Mrs G Findley, Clinical Project Director
Ms D Oliver, Deputy Trust Secretary (Corporate)
Mrs K Ord, Deputy Trust Secretary (Membership, Involvement & Engagement)

21/C/35 Apologies for absence

There were no apologies for absence.

21/C/36 Declarations of interest

There were no declarations of interest.

21/C/37 Introduction

The Chief Executive welcomed Board members to the meeting and introduced Mrs Findley who was currently on secondment from County Durham and CCG and would be helping with the implementation of Trust action plan in response to the CQC inspection in January 2021.

21/C/38 Exclusion of the Public:

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 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 conclusion of the confidential business the meeting closed at 4.42pm

Board of Directors

Public 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	Ref No.	Action	Owner(s)	Timescale	Status
25/02/20	20/44	Revised terms of reference for the QuAC, in regard to the representation from the LMGBs at its meetings, to be prepared and presented to the Board for approval	Chairman of QuAC/TS	~~Feb 21~~ May-21	To be addressed following the governance review
25/02/20	20/46	A re-assessment of the establishment reviews, by exception, to be undertaken	DoN&G	Mar 21	See agenda item 12
25/02/20	20/47	The data on ethnicity in the Equality Data Document is to be aggregated to support comparison when presented to the Resources Committee	DoHR&OD	Mar-21	Completed
26/01/21	21/07	To note the approval of the Carers Charter	DoN&G	-	To note
26/01/21	21/10	To note the approval of the Strategic Framework	DoPCPC	-	To note
26/01/21	21/10	The final draft Business Plan is to be submitted to the March 2021 Board meeting for approval.	DoPCPC	Mar-21	See confidential agenda item 5

Date	Ref No.	Action	Owner(s)	Timescale	Status
26/01/21	21/16	A report on the production of an integrated approach to performance reporting is to be submitted to the Resources Committee	DoPCPC	Mar-21	Completed
26/01/21	21/18	To note that the Gender Pay Gap Report was approved for publication by 30th March 2021	DoP&C	-	To note

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 7

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday, 25 March 2021**
TITLE:	**Chief Executive's Report**
REPORT OF:	**Brent Kilmurray, Chief Executive**
REPORT FOR:	**Information**

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

Executive Summary:

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

Recommendations:

To receive and note the contents of this report.

Care Quality Commission

As advised previously, following the CQC focussed inspection to five adult acute wards in January, the CQC has issued correspondence raising concerns and subsequently enforcement action. The CQC plans to publish its full report on Wednesday 24th March. We will therefore be able to give more information at the meeting, as currently the details within the report are subject to embargo. In the meantime, we have been making good progress with our plans to address concerns and have established assurance processes to ensure patients risks are properly assessed and there are good quality risk management plans (safety summaries).

The Trust has been in liaison with the CQC and other key stakeholders regarding briefings and communications. A letter will go to all inpatients and their carers on Wednesday to explain the situation, offer assurances around actions taken and the opportunity to speak to a manager to pick up any questions.

A more up to date briefing will be provided at the meeting.

Integration and Innovation : working together to improve health and social care for all

At the recent Board seminar we considered the broad implication of the health and social care white paper. In line with our goal of being a great partner we have been working at place, integrated care partnership (ICP) and integrated care system (ICS) level with partners to consider the system implications of the proposals in the document. In line with guidance from NHS England and Improvement, systems have been considering potential operating models and working through the implications for staff employed in CCGs, the ICS programme offices and NHSE/I regional offices.

We have been particularly prominent in discussions within the Durham Partnership on new governance arrangements and in the establishment of the York Health and Care Alliance. Both of these are being developed with an eye to the future operating model and with a clear view on how resources can be maximised to increase integration and improve outcomes. This builds on previous partnership work.

Strategy Launch

The strategy working group has been making plans for the formal launch of our new strategic framework (as approved by Board in January). A short online event is planned for 9.15am on 30th March 2021. The aim is to celebrate the hard work of all of those involved – including over 2,000 staff, service users, carers and partners, and announce our new purpose, vision and goals and showcase our values. Service user and carer contributions will also feature. The strategy is to be called Our Journey to Change in recognition of what people have told us through Our Big Conversation, acknowledging we want to make progress in improving having heard this and demonstrating our ambition. Executives are working with colleagues on the actions, some of which are getting underway.

Covid-19 Update

In line with the prevalence of Covid-19 the number of outbreaks have reduced to 2 (as at 16/03/21) with small numbers of patients and staff affected by Covid-19. This has been reflected by an improving staff sickness position. There continues to be close monitoring of the impact of return to schools and its associated impact on staff who may need to self isolate. The Forensic service has been able to re-open the wards which were brought together under the enhanced Business Continuity Planning (BCP) arrangements as staffing has improved. There remains close oversight of the service to ensure staffing sustainability.

As the position improves, a review of the BCP arrangements will make recommendations as to the oversight of Covid-19, which will enable a shift from the Gold, Silver and Bronze meeting arrangements into “business as usual”.

Covid-19 Vaccine

All staff have been offered the first dose either through our own clinics or acute partners. Dose 2 starts on 29th March and clinics are ready to run. Our current vaccination rate is 84% with more data cleansing underway to align our own and national databases. We are offering monthly conversations via MS Teams about vaccines with colleagues from pharmacy, public health and psychiatry for anyone who has any concerns about either the Covid vaccine or the upcoming flu vaccine later in the year.

We have begun a process whereby we will be combining the risk assessment, wellbeing conversation and opportunity to talk with managers about the vaccine into one conversation and making this conversation mandatory. Initially we will focus on supporting staff who have been shielding as they return to site.

We have vaccinated inpatients in MHSOP, LD, Rehab and SIS services and week commencing 22 March we will be revisiting the wards to offer the vaccination to any new patients on those wards who have not had the opportunity to have the vaccine whilst they were at home. We are also working with AMH colleagues to offer the vaccine to any AMH patients who are likely to still be in our care in April.

Governance Review

The Good Governance Institute (GGI) is about to conclude the Governance Review at the end of this month. They have conducted a number of interviews, observed meetings, spoken to stakeholders and held focus groups. The report will feature a number of recommendations and will provide an opportunity for us to work with the GGI on developing an appropriate development plan. Clearly, at this time other stakeholders will be interested in the review and our subsequent plan. As part of the engagement with GGI we will have access to some of their “academy” materials and training sessions and an opportunity to develop bespoke input from them.

ITEM NO. 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th March 2021**
TITLE:	**BAF Summary**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

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

Report:

The Board Assurance Framework (BAF) is a key means of providing assurance to the Board that the Trust's strategic risks are being managed effectively across the organisation.

The schedule, attached as Annex 1 to this report, highlights the alignment of the BAF risks to the matters due for consideration at the meeting.

It is intended to inform the Board's discussions by drawing attention to assurances to be received; the updates provided on controls; and the progress being made on the delivery of mitigating actions.

Please note that the annex does not reference the consideration of the draft Business Plan (confidential agenda item 5). However the proposed priorities included in that document will support the mitigation of a number of the present BAF risks including promoting user focussed high quality care; consultant recruitment; staff recruitment and retention; developing leadership; and maintaining effective governance.

Annex 1

Summary of Risks included in the Board Assurance Framework
Month: March 2021

Risk Title	Risk Manager	SG	Risk Description	Current Risk Grade	Relevant Matter
Consultant Recruitment	MD	1 & 3	Patient safety, quality and outcomes could be compromised due to difficulties appointing sufficient consultants to meet current and future workforce demands.	**Very High**	
Cyber Security	DoF&I	1, 2, 4 & 5	Patient care could be compromised and there could be reputational damage if a cyber-attack was successful	**Very High**	▪ **Confidential agenda item 9 – Resources Committee Report (update on the delivery of the LAN switches business case) - assurance**
West Lane Strategic Impact	CEO	All	The events in West Lane Hospital Inpatient services in 2019 could have an adverse strategic impact on the Trust particularly through: ▪ Loss of, or disruption to, service provision with consequential impacts on patient experience and clinical effectiveness ▪ Loss of reputation with service users, carers, the public ▪ Being detrimental to staff recruitment and retention ▪ Reducing the confidence of regulators and commissioners in the Trust leading to increased oversight; lower tolerance; and reduced opportunities. ▪ Creating financial pressures	**Very High**	▪ **Confidential agenda item 10 - Report of the West Lane Project Committee - assurances and mitigations** ▪ **Agenda item 7 and confidential agenda item 4 – Chief Executive's Reports (update on the delivery of the CQC action plan) - mitigation**
Maintaining Effective Governance	CEO	1 & 5	There could be repeated failures, unsafe services, regulatory action and reputational damage if we fail to put in place and maintain effective governance, risk and assurance processes.	**Very High**	▪ **Agenda item 7 and confidential agenda item 4 – Chief Executive's Reports (update on the delivery of the CQC action plan) - mitigation** ▪ **Confidential agenda item 7 – BAF Report - assurances** ▪ **Agenda items 14 to 16 – Performance Reports - assurances** ▪ **Confidential agenda item 8 – Audit and Risk Committee Report (approval of the Internal Audit Programme 2021/22) – updated control**

Provider Collaboratives	CEO	All	The establishment of provider collaboratives might impact on the Trust's ability to deliver services particularly in regard to quality, contracting, case management and finances	**Very High**	▪ **Agenda item 7 and confidential agenda item 4 – Chief Executive's Reports (update on the delivery of the CQC action plan) – mitigation**

Compliance with National Targets and Standards	CEO	5	We could be subject to regulatory action and suffer reputational damage if we fail to comply with national targets and standards	**Very High**	▪ **Agenda item 7 and confidential agenda item 4 – Chief Executive's Reports (update on the delivery of the CQC action plan) - mitigation**
					▪ **Agenda items 14 to 16 – Performance Reports - assurances**
					▪ **Confidential agenda item 8 – Report of the Audit and Risk Committee:**
					  ▪ **"Going concern" status – assurance**
					  ▪ **Internal audit findings - assurances**

Coronavirus	COO	All	There could be a significant impact on the Trust's ability to deliver services arising from staff absence and access to supplies due to the Coronavirus	**Very High**	▪ **Agenda Item 7 – Chief Executive's Report (update on the management of Covid-19 and the vaccination programme) – assurance**
Impact of ICS/STP Development	CEO	All	The competing priorities, non-alignment of footprints and varied governance structures of integrated care systems (ICSs)/sustainable and transformation partnership (STPs) could complicate and frustrate the consistent delivery of the Trust's strategic objectives	**High**	▪ **Agenda Item 7 – Chief Executive's Report (Update on the White Paper) - assurance**
Staff Recruitment and Retention	DoHR& OD	1 & 3	Patient safety, experience and outcomes could be compromised if we fail to recruit and retain sufficient qualified and compassionate staff	**High**	
Promoting User-Focussed High Quality Care	MD	1 & 2	The recovery of patients could be compromised if we fail to maintain a culture which promotes user-focussed high quality care in all our services.	**High**	

Roseberry Park Defects - Strategic Impact	DoF&I	1, 2, 3 & 5	The challenging position at Roseberry Park could undermine the delivery of the Strategic Goals and Business Plan priorities and adversely impact on the Trust's financial, reputational and regulatory standing	**High**	▪ **Confidential agenda item 4 – Chief Executive's Report (update on matters concerning Roseberry Park) - assurances** ▪ **Agenda items 14 to 16 – Performance Reports (assurances)** ▪ **Confidential agenda item 6 – Budget 2021/22 (capital programme) - mitigation**
Reputation	CEO	All	A loss of reputation could reduce the confidence of service users and carers to engage with services and commissioners to invest in services which would impact on the Trust's ability to deliver its strategic goals	**High**	▪ **Confidential agenda item 3 – Reportable Issues Log - assurance**
Closed Cultures	COO	1	Failure to identify and tackle closed cultures in our services will increase the risk of harm including abuse and breaches of human rights	**High**	▪ **Confidential agenda item 9 – Report of the Resources Committee -("Learning lessons to improve people practices) – delivery of mitigation**
Benefits from Information Systems	DoF&I	2 & 5	Our ability to deliver high quality, productive care could be compromised if our information systems do not deliver their intended benefits and meet the needs of services.	**Medium**	
Developing Leadership	CEO	2 & 3	Our ability to deliver high quality, productive services could be jeopardised if we fail to develop leadership throughout the Trust	**Medium**	

Quality Assurance Committee Meeting Update

Board of Directors – 25th March 2021

Headlines

This report covers the key issues discussed and decisions made at the meetings held on 4th February and 4th March 2021.

(Approved minutes from 3rd December 2020 and 4th February 2021 are attached as Annex A to the report).

The key concerns to escalate to the Board from February and March include:

>Staffing and medical staffing – particularly in Forensic services where two wards had been temporarily closed.

>The need for a clear line of sight between the NHSEI Quality Board and QuAC.

>Two young people admitted to adult wards.

Trust Wide Quality & Learning Report

Measures showing cause for concern via SPC included:

1. Head of service reviews (Durham & Darlington)
2. Forensic patient safety incidents, reported an increase in November then drop in December.
3. Falls per 1000 bed day which had dropped in January, but still remain above the mean.
4. and self-harm incidents
5. Mandatory training at Trust and locality level further decline in January due to pausing of the indicator in response to pandemic.

Measures via SPC where some improvements have been made:

1. Serious incidents reported below the mean with improvements made in Durham and Darlington
2. Incidents across all localities
3. Shifts greater than 13 hours.
4. 2% increase in compliance with appraisals.

Quality and Patient Safety

- Ligature reduction programme 96% compete. Works on Bilsdale ward due for completion by May.
- Updates were provided, for assurance on infection, prevention and control, safeguarding and information from the Drug & Therapeutics Committee.

CQC Inspection to Adult IP wards

The Committee received a briefing in February on the CQC letters and concerns.
Members sought assurance through future monthly reporting to the Committee.

A further update was received in March that immediate actions had been taken, including daily oversight and audits that had demonstrated improvement.

Early feedback from inpatients had been that the changes had been helpful improvements and there was buy in from staff and patients.

Members requested oversight of the terms of reference for the QI Board and oversight of the outcome of discussions through to QuAC.

CQC 2019 Inspection Action Plan-

Quality Assurance Committee Meeting Update

Board of Directors – 25th March 2021

The five actions behind schedule in February, included:

1. Staffing CAMHS community.
2. MHSOP IP quality assurance audit tool
3. Raising awareness of individual ligature risks to staff on Birch ward.
4. Forensic leave entitlement (impacted by Covid).

Clinical Audit of Emergency Equipment

Good compliance found in the annual audit. Response bags to be changed to improve safety.

Forensic Culture Review

Assurance was provided that the action plan was progressing and staff were being supported.

Update on Q3 current Quality Account and proposed Quality Improvement Priorities for 2021/22

There had been delays with the delivery of actions in the Quality Account due to Covid-19.

Members agreed that there needed to be further work around the development of the new priority “compassionate care” and what that meant.

An updated proposal will report back to the Committee in March.

Clinical Audit Annual Forward Programme

The Committee approved for clinical audit programme for 2021/22.

Serious Incident Review Recovery Plan

The Committee welcomed the improvement on completion of SI reviews - compliance against the 60 day target in January was 100%
SI’s completed in January the three most common root cause or contributory findings were in relation to inadequate record keeping and care planning (27%), risk assessments not carried out (18%) and not following policy (27%)

Quality Assurance Committee Meeting Update

Board of Directors – 25th March 2021

Locality updates include:

	February 2021	March 2021
Durham & Darlington Locality	• Absence rate at 8.5% - Covid affecting staffing levels. • BLS training – some wards at 70% compliance. • Ongoing increased levels of acuity. • Organisational Development team continue working with Crisis Team to improve behaviours and values.	• Implementing new processes and forms onto Paris following the RPIW had been challenging. • Two AMH wards closed to admissions following covid outbreaks. • Staff wellbeing – impact of test and trace on absence. • Restrictions due to level 5 lockdown measures impacting on leave, visiting and staffing. • Ongoing pressures for CAMHS beds and pressure on CAMHS community staff to support adult and paediatric wards for young people admitted.
Teesside	• CQC inspection to AMH in January 2021. • SI in November 2020 on Overdale ward – assurance provided that ligature programme completed. • Safety briefings Trust wide – acknowledged that communication needs to be better. • Staffing issues • CPR training not up to date.	• PDSA approach being adopted to ensure embedding of new process and practice following RPIW in response to CQC inspection. • Self-harm reporting as normal variation however Bransdale Ward in AMH cause for concern. The MDT picked this up and reviewed risks and actions needed. All risk were of low or no harm.
Forensics	• Secure IP service working under business continuity measures • Absence rates for nursing staff at 38% with a vacancy rate of 9% - two wards temporarily closed. Twice daily huddles and daily reviews in place. • Vacancies in physical health – appointment of advance nurse practitioner and nurse consultant • expected in February. • Inconsistent record keeping at ward level and individual restrictive practice records – further work required to make improvements.	• Impact on service in response to change to documentation of risk assessments, in response to CQC concerns not yet fully understood. • Absence rates for nursing staff improved to 17.5%, with a vacancy rate of 7.5%. • Issues raised regarding Thistle ward and the service are reviewing systems, incidents and processes. Additional support has been given to the team and monthly meetings arranged with the leadership team to gain assurance. • Candidates are not attracted to Health and Justice vacancies. Attempts to use agency nursing however there is high national demand.
NY& York	High levels of vacancies in AMH Foss Park Hospital. High referral rates to children's eating disorders – investment priorities agreed with commissioners and opportunity for some possible future funding. Gap in junior doctor cover on Ebor Ward. MD picked this up.	• Impact on service delivery in AMH due to inpatient staff and MDT complying with new safety summary, ward report out process and associated standards. Practice development approach with three meetings per week to monitor progress and provide support to staff. • Rise in complaints across AMH services. LMGB following these up. • High staff vacancies – agency support and overseas recruitment being pursued. • Adult eating disorder contract not finalised for Harrogate.

Item 2

MINUTES OF THE FORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 03 DECEMBER 2020, AT 2.00PM VIA MICROSOFT TEAMS

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mr Dominic Gardner, Director of Operations Teesside
Mrs Ruth Hill, Chief Operating Officer
Dr Pali Hungin, Non-Executive Director
Dr Ahmad Khouja, Medical Director
Mrs Avril Lowery, Director of Quality Governance
Mrs Naomi Lonergan, Director of Operations, North Yorkshire & York
Mrs Shirley Richardson, Non-Executive Director
Mrs Bev Reilly, Non-Executive Director
Mrs Lisa Taylor, Director of Operations, Forensic Services

In attendance:
Mrs Ann Marshall, Deputy Director of Nursing
Mrs Gill Boycott, Head of MHSOP, Durham & Darlington
Mrs Rachel Weddle, Head of Nursing, Forensic Services
Mr John Savage, Head of Nursing, Durham & Darlington
Ms Donna Oliver, Deputy Trust Secretary, (Corporate)
Mr Stephen Davison, Head Nurse, Positive & Safe

Observers:
Mr James Creer, Staff Governor
Mrs Sarah Baxter, Public Governor, Redcar,
Mojgan Sani, Public Governor, Stockton on Tees
Ray Godwin, Staff Governor
Mrs Jill Wardle, Public Governor, Durham & Darlington
Audrey Lax, Public Governor, Durham and Darlington

20/58 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr Brent Kilmurray, Chief Executive, Mrs Elizabeth Moody, Director of Nursing & Quality Governance and Mrs Jen Illingworth, Director of Operations, Durham & Darlington.

20/59 MINUTES OF THE PREVIOUS MEETINGS

Members agreed that the minutes of the previous meeteing held on 5th November 2020 be signed as an accurate record subject to the following:

20/42, Page 3, (2). “There was no provision for backfilling posts, such as the current vacancy for a Deputy Medical Director. *Those kinds of roles are undertaken by including them in a job plan*.”

20/44: Page 5, to remove the incomplete sentence *“This was one incident”.*

20/60 ACTION LOG

Consideration was given to the Action Log and the the following updates were noted:

2.4 Forensic report – bring back action plan and outcome of review.
It was noted that the action plan had been circulated via email to members on 25th November 2020 and would be discussed as part of the agenda (included as an appendices to the Forensic Services LMGB report).

Non-Executive Directors emphasised that they would have preferred this matter to be a substantive item on the agenda, given the sensitivities in the cultural review and that there would be no QuAC meeting until February 2022.

Mrs Hill offered to hold a separate discussion outwith the meeting to answer any further queries or concerns.

20/42 More information to be provided on leave arrangements in Forensic LMGB report.
Mrs Taylor advised members that this matter was due to be discussed at SDG, following which an action plan would be formulated. More information would be provided in due course.

20/43 Update to be provided on clinicians under HR review for sleeping on night duty.
This action would be deferred to the February 2021 QuAC meeting.

20/61 NORTH YORKSHIRE SERVICES UPDATE

The Committee received the report.

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

(1) A request had been made to silver command to reduce the number of beds on Danby and Esk Wards to retain the current locum Consultant who had been covering both areas. The locality medical workforce was working through how this could be resolved.
(2) Increased volume of child eating disorder referrals – urgent assessments were being offered by the team by flexing the available capacity.
(3) A higher incidence of falls, which was most likely related to Covid-19 and the need for cohorting plans. Training was being provided by Physiotherapists and improvements had been seen. This was being monitored closely at QuAG/LMGB level.
(4) Oak Rise had been closed to admissions due to one covid-19 positive patient that required ECT therapy. This matter would be discussed at the Ethics Committee.

Non-Executive Directors queried the following:

(1) Whether there was any correlation between the three nurses that had handed in their notice on Oak Rise.
Mrs Lonergan noted that there had been a domino effect, which had been caused by a feeling of instability on the ward when there had been a reduction of patients earlier in the year, coupled with other more attractive employment options.
(2) Whether the number of falls reported was a significant increase.
This matter would be picked up in the next LMGB meeting to check that the number of falls were reducing.
(3) How much confidence there was in the recruitment of a replacement Head of Nursing to the locality.
It was noted that the post had gone out to advertisement, however it was difficult to provide any certainty on a successful re-appointment at this stage.

Additional reporting included during November 2020 there had been no breaches with checking emergency equipment and no instances of the use of mechanical restraint or tear proof clothing.

20/62 FORENSIC SERVICES UPDATE & FORENSIC SERVICES CULTURE REVIEW ACTION PLAN

The Committee received and noted the reports.

Arising from the Forensic Services update report it was highlighted that the top concerns were:

(1) Issues have been raised with Spectrum, the prime provider regarding the high number of referrals to HMP Durham prison and business continuity plans had been implemented
(2) There had been a deep dive of cancelled leave from August to October 2020 and a plan based on the findings was being developed. The position would be reported through to QuAC in February 2020.
On this matter members recognised that it was important that any leave was planned and productive for patients. Mrs Taylor advised that the Multidisciplinary Disciplinary Team (MDT) were picking that up.
(3) A ward improvement plan had been implemented where there had been previous concerns over staff attitude, particularly in relation to black and ethnic minority groups.
On this matter it was noted that investigations were still ongoing.
(4) Staffing issues on Brambling ward due to staff wanting to move due to the high level of acuity and an ovaerall shortage of staff wanting to work in female services leading to pressures and staff sickness.
(5) Two nurse secondments had been developed in response to pressures in Health and Justice and the high number of outbreaks.

The Committee received and noted the Forensic Services Culture Review Action Plan.

It was noted that the action plan had been circulated to Committee members prior to the meeting.

Non-Executive Directors queried whether the action plan contained a culmination of all actions following the CQC visit, the ward manager review and external review and had been shared with staff.

Mrs Taylor advised that opportunities to share information with staff around the ongoing work within the Forensic culture plan would take place in the coming weeks. There had been delays caused by Covid-19.

Members considered that the Board should be updated on the Forensic Services Action Plan through the QuAC report and that a stand alone update item be reported to the February 2021 QuAC meeting. Mrs Hill advised that it would be worthwhile holding a separate briefing meeting with Non-Executive Directors outside the QuAC meeting before the next meeting.

Action: Mrs Hill

Mrs Lonergan left the meeting

Non-Executive Directors requested that future update reports around the Forensic Services Review be written succinctly to provide assurance, rather than be too detailed.

20/63 DURHAM & DARLINGTON SERVICES UPDATE

The Committee received and noted the report.

Arising from the report it was noted that the top concerns were:

(1) Increased waits for autism and ADHD assessments – teams had been busy identifying trajectories to incorporate the backlog as formulations were back to March 2020 with levels of 24 per week.
(2) The deteriorating position of care homes due to impact of Covid-19. Recruitnebt to enhanced CHL Hub and Care Home Wellbeing Service had been progressing well.
(3) Pressures around supporting a number of patients in the Tees patch.
That had resulted in tight bed capacity and high acuity, however the situation had been managed through flexible approaches to staffing.
(4) There was a recognition of the vulnerability for those with learning difficulties. Individual risk assessments would be made with reasonable adjustments offered.
(5) In November 2020 a vulnerable patient had died of Covid-19 which had been due to nosocomial transmission, which had impacted on the ward and staff involved.

Additional reporting included during November 2020 there had been no breaches with checking emergency equipment. There had been no instances of the use of mechanical restraint and no episodes of the use of tear proof clothing.

In response to queries from members it was noted that:

(1) Tackling improvements around risk assessments was being driven through the Clinical Leaders Group. The Chairman raised concern over a coroners verdict that stated the lack of assessment had contributed to a suicide (page 2 of the report).
The Medical Director provided assurance that various methods were being used through training materials and a suicide risk assessment would be built into Cito.

20/64 TEES SERVICES UPDATE – QUALITY ASSURANCE AND LEARNING REPORT

The Committee received and noted the newly formatted locality report for Tees services.

Standardising the locality report had been one of the key recommendations following the QuAC Away Day to improve the reporting and levels of assurance provided to the Committee.

In introducing the report Mr Gardner highlighted:

(1) That the revised style format would will be piloted for three months.
(2) The new layout, centred around the CQC domains, contained SPC charts and a “what”, “so what”, “now what” approach, as well as identifying how learning would be used to make improvements.
(3) That the report would be fed into the Quality Assurance Groups (QuAG) for the locality and shared with teams to disseminate the information.
(4) That staff morale over the second wave of the pandemic had demonstrated significant flexibility in dealing with different outbreaks. Levels of sickness had been no where near what neighbouring acute Trusts were witnessing.
(5) There had been an incident on Overdale Ward of self harm and anti ligature works were being expedited.

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

(1) The Impact of Covid-19 increased infection rates on staffing with increased use of bank and agency staff. Assurance was provided that the skill mix was being reviewed daily.
(2) It had been difficult to maintain services and bed admissions during the periods of outbreaks of Covid-19. Daily bed management calls had been put in place.

(3) Cohorting plans were being reviewed due to the high levels of self-harm incidents. There had been 22 attributable to AMH inpatient services and 13 involving a ligature. Options were being looked at to provide alternative capacity to expedite ligature works. The ligature risks had been particularly high amongst females. There were ongoing discussions about how to mitigate risks.

Additional reporting included that during November 2020 there had been three instances where the resuscitation equipment had not been checked on two wards and one use of tear proof clothing.

Following discussion:

(i) Members of the Committee welcomed the newly formatted report as it contained a sharper more focused narrative with relevant analysis and assurance. There were however, some technical difficulties viewing all of the data on IPads for the Non-Executive Directors. Mrs Lowery advised that a way of sharpening the detail had been found and future reports, it was hoped would be clearer for reading.

The Chairman thanked the Quality Governance team for their work in pulling the report together. He also suggested some thought to be given to whether the Committee should receive two localities per meeting, rather than four, in order to give more time for focus on the issues. Non-Executive Directors were in agreement that bi-monthly reporting would be more effective.

Following the Good Governance Institute (GGI) Trust review and revision of the time table for the Sub-Committees to the Board this could be considered.

(ii) Mr Gardner noted that the report, although it had taken some time to put together was helpful in looking across the service at the various levels of performance and quality of care and would be used to make improvements where necessary.

(iii) The Chairman recognised the impressive commitment and flexibility of staff across the Trust, in all localities, in managing the onoing difficulties cased by Covid-19.

In response to queries it was noted that:

(1) The second wave of safe staffing review would be taking place, which should be completed by January 2021. Some areas of the service had been overstaffed in response to changes around enhanced observations. The base line establishments were being looked at.

(2) There was a variation in the numbers around patients feeling safe and it was recognised that it was difficult trying to capture how safe an individual felt when they were acutely unwell on a ward. Discussions would continue about this matter at the Locality Management and Governance Board.
Mrs Lowery added that some focus was needed going forward on how to measure patient experience aswell as to make improvements.

20/65 TRUST WIDE QUALITY & LEARNING REPORT

The Committee received for the first time a Trust Wide Quality & Learning Report.

In introducing the report Mrs Lowery highlighted:

(1) The integrated report had been developed to combine a number of individual reports into one overarching document with details around the monitoring and assurance of quality indicators.

(2) Information contained in the reported featured SPC charts with explanatory narrative focused around the CQC domains.
(3) The report had been produced in the same standardised layout as the revised locality report, which Teesside would be piloting for three months.
(4) Some of the benchmarking in the CQC Insight Report published in October 2020 had revealed areas where the Trust compared better than nationally around proportion of sick days in the last 12 months for nursing associates, staff believing they had adequate material resources and staff receiving updates on patient feedback.
(5) In the June 2020 Insight publication the Trust had been detailed as worse compared nationally for detained patient deaths (Trust flagged for risk in the number of suicides of patients detained under the MH Act – all ages).
On this matter the Chairman queried how concerned the Trust should be since the CQC had not yet identified whether the Trust was a national outlier for this indicators and there had been no comparable data to benchmark against.
Mrs Lowery undertook to find out more information and report back to the next Committee.

Action: Mrs Lowery

Following discussion:

(i) Members welcomed the presentation of the quality information setting out statistical process control charts for 16 of the 26 measures identified. Also, that the data framed around the CQC headings of "safe, effective, caring, responsive and well led" and the strategic goals enabled clearer understanding of the key issues.
(ii) It was noted that the Trust wide indicator for 'whistleblowing alerts received by the CQC' had flagged as 'much worse compared nationally'.
The Chairman requested further information on this and it would be reported to the February QuAC meeting.

Action: Mrs Lowery

Non-Executive Directors acknowledged the significant progress that had been made with serious incidents and thanked the Patient Safety team for all their efforts and hard work.

20/66 QUALITY & SAFETY KEY INDICATORS REPORT

The Committee received and noted the monthly update report on Quality and Key safety indicators.

The key matters highlighted from the report were:

(1) The Trust position showed three areas with no variation. Three areas were reporting special cause variation – improvement for the number of shifts worked greater than 13 hours, Serious Incidents and Head of Service Reviews). Some work would be undertaken to look at any themes across the shifts worked and whether there were any particular wards affected more than others.

(2) The locality position showed five areas with no variation and one area indicating special cause variation – improvement for number of shifts worked greater than 13 hours. (North Yorkshire & York and Teesside).

The Chairman questioned whether this report was still required for presentation to the Committee based on there being duplication in the information presented in reports. Non-Executive Directors welcomed the new style of reporting to reduce the heaviness of reporting on agendas and to enable more focus on the key elements of business to gain better assurance. All were in agreement that the level of detail was too great rather than a focus on what was required to provide quality assurance.

Mrs Loewry advised that due to the newly formatted Trust Wide Quality and Learning Report consideration would be given to whether this report would be needed in future.

Action: Mrs Lowery

20/67 CQC ACTION PLAN UPDATE

The Committee received and noted an update on the CQC action plan as at 25th November 2020.

Arising from the report it was noted that of the 19 actions, 9 had been completed, two required submission of supporting evidence to facilitate sign off and four actions were in progress within timescale. There were four actions behind schedule.

The Chairman of the Committee sought assurance on the oversight of the actions and assurance was provided that there was rigorous monitoring by the Compliance Team, alongside operational services with progress reports to the Quality and Safety cell weekly.

Non-Executive Directors queried the suspension of the Quality Compliance Group, during business continuity however, it had been reinvigorated via a webinar on 19th November 2020 to share and spread information.

20/68 EXCEPTION REPORT ON KEY AREAS OF QUALITY AND SAFETY

The Committee received and noted the monthly update report, as at 19th November 2020.

The key matters highlighted were:

(1) Safeguarding adults and children, infection, prevention and control, learning from Covid-19 related deaths, pharmacy, and delivery of the ligature reduction programme.
(2) There were eight wards where the ligature reduction programme was outstanding and plans were in place for completion.

20/69 COVID-19 SILVER COMMAND QUALITY & SAFETY CELL UPDATE REPORT

The Committee received and noted the update report.

This update report provided QuAC with an overview of the issues discussed by the Quality & Safety cell and the key matters of focus.

The committee recognised that there was repetition in the information contained and covered in this report and following the introduction of the new Trust wide Quality & Learning Report consideration would be given to whether this report would be required at the February 2021 meeting.

Mrs Lowery provided assurance that the key risks had been covered in other reports presented to the meeting.

20/70 HEALTH, SAFETY, SECURITY & FIRE REPORT

The Committee received and noted the first update from the Fire, Safety, Security & Fire Group since before the pandemic and the Committee had gone into “agile” working.

Assurance was provide that there were no risks or concerns around the monitoring of controls, key performance indicators and work plans.

20/71 ANNUAL REPORTS

The Committee received the following Annual Reports:

(i) Patient Safety
(ii) Complaints and PALS
(iii) Patient Experience
(iv) Clinical Audit & Effectiveness
The Chairman queried the audits assigned red. It was noted that some of them would be completed and some not progressed due to Covid-19. The details of outstanding audits would be provided
(v) Positive & Safe
(vi) Infection, Prevention & Control.

Non-Executive Directors queried which Trust wide Annual Reports were presented to the Board of Directors. They also welcomed the condensed shortened version that had been presented to the Committee.
Ms Oliver undertook to circulate the information to QuAC members.

Action: Ms Oliver

20/72 KEY ISSUES DISCUSSED THAT REQUIRE ESCALATION TO THE BOARD

There were no issues that required escalation. The only matter to draw attention to was that there would be a separate meeting held with the Non-Executive Directors to update them on the Forensic Services Culture action plan.

20/73 COMMITTEE EVALUATION

Members were content with the administration of the meeting and reports presented and had been very impressed with the new style of reports.

20/74 DATE AND TIME OF NEXT MEETING

The next meeting of the Quality Assurance Committee will be held on Thursday 4th February 2021, 2.00pm – 4.30pm via Microsoft Teams.

The meeting concluded at 4.55pm

……..
Dr Hugh Griffiths
Chairman

Item 2

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 11th FEBRUARY 2021, AT 2.00PM VIA MICROSOFT TEAMS

Present:
Hugh Griffiths, Chairman of the Committee
Dominic Gardner, Director of Operations, Teesside
Ruth Hill, Chief Operating Officer
Pali Hungin, Non-Executive Director
Jennifer Illingworth, Director of Operations, Durham & Darlington
Ahmad Khouja, Medical Director
Avril Lowery, Director of Quality Governance
Elizabeth Moody, Director of Nursing & Quality Governance
Shirley Richardson, Non-Executive Director
Bev Reilly, Non-Executive Director
Lisa Taylor, Director of Operations, Forensic Services

In attendance:
Donna Oliver, Deputy Trust Secretary, (Corporate)
Sarah Theobald, Head of Corporate Performance

Observers:
Gill Findley, Clinical Project Director
Hazel Griffiths, Public Governor, Harrogate & Wetherby
Jules Preston, Public Governor, Harrogate & Wetherby
Emily Sheen, Consultant, Good Governance Institute

21/01 APOLOGIES FOR ABSENCE

Apologies for absence were received from N Lonergan, Director of Operations for North Yorkshire & York and S Pickering, Director of Planning, Performance, Commissioning and Communications.

21/02 MINUTES OF THE PREVIOUS MEETING

Agreed:

That the minutes of the previous meeteing held on 3rd December 2020 be signed as an accurate record subject to the following:

The addition to page 5, Tees Report, second paragraph: "The Chairman thanked the Quality Governance team ***and the Director of Operations for Teesside,*** *for their work in pulling the report together".*

21/03 ACTION LOG

Consideration was given to the Action Log and the the following updates were noted:

20/65: Trust wide Quality and Learning Report: (ii) It was noted that the Trust wide indicator for 'whistleblowing alerts received by the CQC' had flagged as 'much worse compared nationally'.
The Chairman noted that he had recollected a discussion around the deaths of detained patients reported in the CQC Insight report and whether it could be checked if the reporting of whistleblowing had also been an outlier for the Trust.

The Director of Quality Governance undertook to clarify the two matters and report back to the March QuAC meeting.

Action: A Lowery

20/43 An update on the HR review of clinicians asleep on duty.
It was noted that the HR review of six members of staff was still ongoing and an update would be brought to the March 2021 meeting.

Action: J Illingworth

20/43 (iv) LD Day services: to understand whether any operational or staffing issues about clients accessing services resulted in the need for more medication requirements.
It was noted that the issues with accessing LD day services had been more of a national concern, however work was underway with Local Authority colleagues to flag any concerns. There had been some issues with LD care homes, which had been flagged up through the quality processes.

20/65 Trust wide Quality and Learning (Q&L) Report: to provide more information about death of a detained patient.
The Director of Quality Governance noted that this had been in relation to information in the CQC Insight report. The Trust had queried the information, which had now been suspended and the methodology was going to be reviewed. There had been no further updates.

21/04 LOCALITY REPORT: TEESSIDE

The Committee received and noted the Tees Locality report.

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

(1) The CQC had inspected adult inpatient services in January 2021 with a Section 31 warning letter being issued to the Trust. (The matter would be covered as a stand alone item later in the agenda).
The main concerns raised had been around duplication and over complication of existing processes and the assessment and recording of patient risk. Immediate actions had been taken and were being monitored on a daily basis.
(2) The impact of Covid infection rates on staffing with risks around relying on bank and agency staff, continuity of care and potential quality and safety issues related to the reduction in knowledge about Trust systems and processes. Also, around bed availability during outbreaks, which had been putting pressure on other wards.
(3) A serious incident had occurred in November 2020 at AMH Overdale Ward which had resulted in the death of a service user and had been through the use of a ligature. There had been two further incidents in December, which had required L4 Head of Service Reviews, again, both relating to ligatures. In these two cases the ligatures had not been attached to an environmental point on the ward.
(4) Difficulties delivering the ALD respite service in the current environment whilst trying to maintain IPC requirements. A servce review was being undertaken of the outreach service offered.
(5) There were two measures reporting concern - falls and mandatory training.
On this matter it was highlighted that the number of falls had increased in correlation with more reporting of falls.

The Director of Quality Governance reported that following a meeting with the Trust lead on falls there was some work underway in relation to compliance with the post falls bundle which is aimed at reducimg the risk of wsubsequent falls.

On the matter of mandatory training it was pointed out that the data was currently incorrect and work was being undertaken by the Trust to resolve this.

Non Executive Directors queried the following:

1. The ligature programme at Overdale Ward.
   It was noted that the works on Overdale Ward had been completed and the outstanding programme would be shared with QuAC.

   Action: D Gardner

2. Whether the learning had been shared from the Heads of Service reviews.
   It was noted that learning lessons through daily audits of risks were being communicated through the Trust wide safety briefing. There was however, more improvements to be made by tightening up the levels of communication to ensure that a difference would be made.
   There was however, more improvements to be made in relation to sharing organisational learning from Heads of Service reviews now they had passed back to the services.

3. Safe staffing concerns and whether there was a need for an establishment review.
   The Director of Nursing & Governance highlighted that the safe staffing report was due to be presented to the Board of Directors, at its meeting to be held on 25th March 2021.

   It was interesting to note that the Trust had been working at over established staffing levels duruing the pandemic with the need to open up more wards. This had meant that the base line establishment staff levels from the previous year (pre Covid) would be used to plan for the future.
4. Staffing issues, particularly in Forensics and whether there had been any analysis around the increased use of bank and agency staff. Also, whether there would be a point when the Trust would need to consider bed closures if the wards became unsafe.
   The Chief Operating Officer advised that decisions had been made, where necessary to close beds to date, such as Elm Ward, which had been for safety reasons, however any ward closures would not be for the long term.
5. CPR assurance audit and concerns around staff not being trained.
   It was noted that there had been a deterioration around training levels due to the inability to provide face to face training. Plans were in place to implement an E-learning course in order to improve standards.

Additional reporting included that during December 2021 there had been no use of mechanical restraint. There had been a discrepancy around the recording of tear proof clothing with conflicting results on the quality and learning dashboard and the positive and safe dashboard. This was being investigated.

Compliance around checking emergency resuscitation equipment revealed two wards within AMH acute services where checks had not been made on seven occasions. This was being followed up by ward managers with daily checks.

21/05 LOCALITY REPORT: NORTH YORKSHIRE & YORK

The Committee received and noted the the North Yorkshire & York locality report.

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

(1) Workforce issues, with increased number of vacancies in adult mental health at Foss Park Hospital. Staff had been mobilised from the community to help out and ensure safe staffing levels.
(2) Increased referral rates for eating disorders. Some investment priorities had been agreed with Commisioners and recruitment would commence from April 2021. Some possible funding stream had also yet to be confirmed from Humber Coast & Vale ICS.
(3) There had been a gap in junior doctor cover on Ebor ward from 3rd February 2021. Non-Executive Directors sought assurance that the matter had been resolved and whether there could be any nursing support offered.
The Medical Director undertook to ensure that a Trust Doctor be deployed for the purpose of covering the core trainee.

Action: A Khouja

The Chairman congratulated the locality on the recruitment plans for CAMHS with six people to interview for four posts. The Medical Director informed members that a lot of work had gone into making posts desirable for applicants.

Additional reporting during December 2020 included that there had been no breaches with checking emergency equipment. There had been no instances of the use of mechanical restraint device and no episodes of the use of tear proof clothing.

21/06 LOCALITY REPORT: FORENSIC SERVICES

The Committee received and noted the Forensic Locality report.

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

(1) Due to extreme staffing pressures the secure inpatient service was working under business continuity arrangements. Absence rates for nursing staff, as at 21st January 2021 was at 38%, coupled with a vacancy rate of 9%. This equated to a total of 52%.
On this matter it was noted that daily reviews of staffing and twice daily huddles were being held, with various measures being used to alleviate the pressure.

Since writing the report staff had been deployed from Tees services and the senior team had been working on the wards with the overall aim of keeping patients safe. Due to the staffing pressures however, it had been necessary to temporarily close two wards. The wards would be reintroduced once there was a safe staffing compliment.

(2) Vacancies in the Physical Health Team could potentially impact on service delivery. Appointment to Advanced Nurse Practitioner and Nurse Consultant roles in February 2021 were expected which it was hoped would alleviate some of the pressure.
(3) Difficulties receiving timely updates on the outbreak staff lists and managing IPC issues in non-TEWV environments (prisons). The Health and Justice Head of Service was actively working with partner agencies.
(4) There had been three wards found to have plastic bags in patient bedrooms. Security checks would be stepped up and this would be reinforced at the Quality Assurance Group (QuAG). Members queried whether any additional actions were required around this matter, perhaps increasing communication with staff on a daily basis.

It was noted that monthly checks had been replaced by weekly at different points and that ad hock checks were also in place.

(5) There had been a lack of consistency between ward level and individual restrictive practice records The Chairman sought assurance around the impact following the CQC inspection. The Director of Forensics advised members that matters had been rectified following the audit of the records, however there was admittedly some further work required across the site.

(6) Health and Justice had been experiencing high levels of covid outbreaks with prison officers and staff testing positive.
The Chief Operating Officer questioned whether the routes of escalation were adequate and whether anything more needed to be done to make staff feel safe.
The Director of Forensics advised that there had been a clear focus on staff wellbeing and safety and that prisons were currently at level 4 meaning that the level of activity had reduced.

Additional reporting during December 2020 included that there had been two breaches with checking emergency equipment and four occasions when items had been missing.
There had been three instances of the use of soft restraint devices, two for hospital transfer and one for transfer to seclusion. There were four episodes of the use of tear proof clothing, all of which had been pre-authorised.

The Chairman noted that there was a tendency to include operational details in the locality reports, which was not required for QuAC. This should be resolved when the three localities (D&D, NY&Y and Forensics) moved to presenting the locality information in the newly formatted - Quality and Learning report, which had been piloted for two months, since November 2020 by the Teesside locality.

21/07 LOCALITY REPORT: DURHAM AND DARLINGTON

The Committee received and noted the Durham and Darlington locality report.

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

(1) Staffing levels due to positive Covid tests, long covid and the need for shielding. Staff well-being continued to be of focus with daily locality leadership calls in place to monitor the impact. Absence rates had been at around 8.5%.
(2) BLS training was a concern with some wards only at 70% compliant. The position was being monitored and training dates highlighted to staff for booking.
(3) The acuity on adult wards had increased significantly.
(4) The first disciplinary hearing had taken place regarding the clinical staff that had been found sleeping on shift. An update would be reported to the next meeting.
(5) The crisis team work continued with organisational change planned to improve relationships, behaviours and the values of the team, being mindful of their impact on patient safety. Staff side had also been included in the work.
(6) Some initial work had been discussed with regards to changing adult PICU to a single sex unit.
(7) Agreement was needed around exploring student placements and the ability to work remotely. On this matter it was highlighted that a bid had been submitted to secure some IT equipment for students.

The Director of Durham and Darlington highlighted that working differently over the recent months had included going to individual's homes if appointments were cancelled.

In addition to the report, it was noted that there had been an outbreak of Covid on Elm Ward which had led to a female patient being isolated in Oak Ward.

Additional reporting included that during December 2020 there had been full compliance with the checks around the resuscitation equipment. There had been one episode of the use of mechanical restraint in LD services and no use of tear proof clothing.

In response to a query about the covid vaccination programme and whether it could be done at home if people were unwilling to leave their premises, it was noted that the four vulnerable groups were currently being offered the vaccine in order, with the over 80's first, followed by over 70's and Learning Disabilities and Forensics.
The Director of Nursing and Governance stated that when staff visited wards they would vaccinate as many individuals as they could on the day.

21/08 EXCEPTION REPORT ON KEY AREAS OF QUALITY AND SAFETY

The Committee received and noted the Exception Report on key areas of Quality and Safety.

The key matters highlighted were:

(1) Updates on the activity around safeguarding, infection prevention and control, the flu vaccine and an update from the Drug & Therapeutics Committee held on 26th November 2020.
(2) There had been a number of drug incidents relating to errors in positive patient identification. The introduction of wrist bands for patients and the inclusion of a photograph within KARDEX had been accelerated.
On this matter it was highlighted that the introduction of patient photographs had been discussed at the Digital Safety Board meeting and it would be key that the wards work with patients to act in their best interest.
(3) The ligature reduction programme was reported as 96% completed.
Members queried whether the works on Bilsdale could be expedited which were not due to start until 15th March with completion by the 7th May 2021.
The Director of Nursing and Governance explained that there was a firm commitment to enable the works as soon as practicable, which would involve removing full ensuite facilities, leading to a reduced bed capacity.
(4) The appendices included new and escalated risks together with the outcomes of mini environmental audit results.

In response to queries it was noted that:

(1) The Trust risks were managed at locality level through the QuAGs and LMGBs with the corporate risk register reporting to the Senior Leaders Group.
(2) There had been some noted improvements made in relation to the risk register and the quality of entries including controls, assurance and actions. There was also a piece of work to take place with the Board around risk appetite.
(3) The flu vaccination programme was currently at around 71% uptake, which was a significant improvement from last year. The uptake of Covid vaccinations was reported as higher at around 80-85%.

The Chairman drew attention to reporting to Committee and noted that:

(a) Updates had been reported in a combined way whilst the Committee had been working in "agile" format and queried how reporting from the Sub-Groups to QuAC would look in the future.

It was suggested that the Exception Report on the key areas of quality and safety would continue, with the addition of rolling focused reports from the areas of Patient Safety, Patient

Experience and Safeguarding. (These were some of the reports that had previously been reported through from the Sub-Groups to QuAC, before the onset of the pandemic).
Non-Executive Directors requested that any future reporting from the Sub-Groups to the Committee present the information in the two sided briefing format, which had been adopted by Drug & Therapeutics and the Research & Governance reports.

Non-Executive Directors queried the rate of progress in response to the recent safety concerns raised by the CQC.

The Director of Quality Governance reported that:

(a) The focus from the CQC perspective had been around how the Trust should improve patient safety in relation to risk assessments, care planning and quality of this documentation, ensuring information is recorded in the correct place.
(b) There had been an improvement event in response to these concerns, that had focussed on clarifying stanards, reducing complexity and duplication regarding documentation to facilitate better communication and enable safe patient care. What had been impressive was the tremendous response from colleagues across the Trust and the collaboration of work to make the necessary changes. This work continued and processes were in place to monitor progress and ensure patient safety.

21/09 CQC INSPECTION AND TRUST ACTION PLAN UPDATE

The Committee received and noted a verbal update on the Trust response to the CQC inspection.

The key matters highlighted from the report were:

(1) The Trust had submitted an action plan in response to the CQC Section 31 letter of intent issued on 25th January 2021.
(2) A further letter had been received on 4th February 2021: Section 29A Warning Notice setting out that the Trust would need to make significant improvements by 3rd May 2021.
(3) A rapid programme of work that then been undertaken to take immediate action.
(4) Next steps would include:
    - Weekly CEO Chaired Quality Improvement (QI) Board.
    - Overseeing the implementation of Rapid Improvement outcomes.
    - Scoping and implementation to specialties.
    - Linkages with the existing CQC action plan.
    - To ensure broader connection to the Trust strategic direction, key projects and programmes.
    - Stakeholder, service user and carer engagement and communications.
    - Oversight and assurance through the QI Board, QuAC, Board of Directors and lead Non-Executive Director.

Members of the Committee highlighted the need for sufficient engagement with staff and the need for some clarity around the terms of reference from NHSE for the Quality Improvement Board. They also requested a stand alone item on future QuAC agendas.

Action: E Moody

In response to a query it was noted that the terms of reference for the Quality Improvement Board would be prepared by around the 23rd February 2021.

21/10 UPDATE ON PROGRESS WITH TRUST CQC ACTION PLAN ASSURANCE REPORT

The Committee received and noted the update report on progress with the CQC action plan.

It was noted that of the nineteen actions had been completed there were five behind schedule at the beginning of February 2021.

- Action 4: CAMHS Community, staffing levels to be regularly reviewed to meet the needs of the population. The staffing establishments, impacted by Covid had been reviewed and shared with Commissioners.
- Action 15: MHSOP inpatient, quality assurance audit tool would include a peer review system for Modern Matron checks which are being embedded.
- Action 17: further work required to raise staff awareness of surveys and mitigation of individual ligature risks on Birch Ward.
- Action 19: forensic inpatient staffing levels on Mallard and Linnet wards should not impact on patient's ability to take section 17 leave. It was recognised that tier 4 covid guidance restrictions was causing some limitations to leave.

21/11 TRUST LEVEL QUALITY AND LEARNING REPORT

The Committee received and noted the update report.

The key matters highlighted were:

(1) The report, being presented to the Committee for the second time, was still a work in progress. There were numerous references to "further work required" in the report, however the aim would be that those references would decrease in future iterations, with more explanatory narrative included and what was being done to make improvements.

(2) There were four measures from the SPC charts causing concern, which included:
- Head of service reviews, with an increase in November and December 2020, with Durham and Darlington locality being cited as contributing to the increase.
- An increase in patient safety incidents in Forensics during November, with a drop in December 2020. There was further work to be done to understand the reasons. The drop in December was attributed to the North Yorkshire and York purpose built facilities.
- The rate of falls per 1000 occupied bed days (OBD) had declined, however was still above the mean.
- Mandatory training had shown further decline in December 2020, due to pausing the compliance rating at 31st March 2020 to allow operational services to devote time to clinical practice.

(3) Self harm incidents had reported an improvement in December 2020 for secure inpatient services.

(4) Durham and Darlington reported cause for concern over the number of self harm incidents and work was required to understand that further.

The Chairman sought further assurance around how the further work required around falls and self harm would be reported back to the Committee.

In response, it was explained that there needed to be further interrogation and understanding of the data in relation to the particular service, in order to be able to contextually consider the

information. There would be further details provided in next months report to the March 2021 QuAC meeting.

Action: A Lowery

In response to queries it was noted that:

(a) The staff experiences collated during the Covid pandemic had been completed by individuals anonymously in a feedback survey. The quotes provided in the report were from members of staff in a particular team and whilst it might not be representative of the whole Trust it would be an area that could be developed in the future for obtaining staff feedback.
(b) The body camera pilot had been taking place across five wards, which was considered to be a limited picture of the impact and effectiveness. The response had already shown that it was possible to de-escalate more rapidly through wearing the cameras.
A paper would be presented to the Senior Leaders Group next week recommending that the pilot be extended to a further five wards. An update would be brought to the March QuAC meeting.

Action: E Moody

(c) The timing of the next update report to QuAC from Positive and Safe would be confirmed.

Action: E Moody

21/12 SERIOUS INCIDENTS (SI) REVIEW RECOVERY PLAN

The Committee received and noted an update report on review of Serious Incidents.

The key matters highlighted from the report were:

(1) Compliance with the 60 day target for the completion of serious incidents had been an ongoing challenge.
(2) Following implementation of a revised recovery plan in October 2020 there had been a three day training workshop held in December 2020, involving senior clinicians. All incidents had then been allocated a reviewer and the compliance rate had reached 63% by January 2021.

The Chairman queried whether the recovery position of compliance with the 60 day timeframe would be hindered by those serious incidents that were reviewed more than once.

The Director of Quality Governance advised that each SI reviewer had a buddy in the Patient Safety Team to support the process and that there had been a marked improvement in the quality of the reviewing.

21/13 CLINICAL AUDIT OF EMERGENCY EQUIPMENT REPORT

The Committee received the Trust wide clinical audit of emergency equipment 2020/21.

The key outcomes of the audit were:

(1) The annual audit of had been undertaken a the request of the Quality Assurance Committee in order to monitor and provide ongoing assurance around compliance with the associated practice standards.
(2) There had been high levels of compliance found in the audit with any minor issues found immediately addressed and actioned to mitigate against potential risks.

(3) Some of the risks identified had been around the lack of clear signage for the location of oxygen, equipment not ready for immediate use and all the necessary equipment for adults and children not being present.
(4) Ongoing governance of the emergency equipment would include monthly checks by Modern Matrons, which would be reported through to the relevant forum.

The Director of Quality Governance drew attention to the plans around introducing new quipment, where it would not be possible to disrupt the items in the emergency response bag, which would ultimately improve safety.

The Chairman noted that the audits of the emergency equipment had been an ongoing matter following a CQC inspection three years ago where issues had been raised. It was encouraging to see that compliance was better and the implementation of the new equipment would add further improvements.

21/14 FORENSIC SERVICES CULTURE REVIEW UPDATE

The Committee received and noted an update report on the Forensic Services Culture Review.

The key issues to highlight were:

(1) The update had reported to QuAC as a stand alone item at the request of the Committee at the December 2020 meeting.
(2) In taking the actions forward there would be a clear focus on making sure staff felt supported.
(3) The delivery plan assurance statement set out the governance arrangements for the progress on actions.

Members added that they had been satisfied with the line of oversight on the progress with the action plan and had welcomed the separate meeting for further assurance.

The Chairman requested that the next and future updates be included with the Forensic locality report.
Action: R Hill

21/15 RESEARCH GOVERNANCE (R&D) GROUP

The Committee received and noted an update from the Research and Governance Group.

The key matters highlighted from the report were:

(1) The report had been refreshed and presented in a two page summary briefing which members welcomed.
(2) The impact of the pandemic, which had led to some research studies being suspended and then re-started. The National Institute for Health Research had categorised study priority and the Clinical Research Network funded staff had been diverted to support priority urgent public health studies. Some of the R&D staff had supported front line clinical services through corporate redeployment.
(3) The Research & Development strategy was currently being developed and would include strong links with clinical services, with the growth of new Clinical Academics to ensure that research undertaken and led by TEWV would be relevant to the local populations.

The Medical Director requested that future reports provide information around how the Trust had been adhering to research governance guidelines. That would provide the level of assurance for the Committee, that the governance arrangements for research were in place.

Action: D Ekers

20/72 KEY ISSUES DISCUSSED THAT REQUIRE ESCALATION TO THE BOARD

Following discussion members agreed that there were no significant matters to escalate to Board, however there were two key issues to reflect, which were:

1. Staffing levels, particularly in Forensics where two wards had been closed due to the pandemic.
2. The governance arrangements around the NHSE Quality Improvement Boards, the terms of reference and to ensure that there was a clear line of communication to QuAC on a regular basis.

20/73 COMMITTEE EVALUATION

Members were overall content with the reporting on the agenda.

Following discussion, members considered:

1. Reporting to QuAC from the localities.

(1) Non-Executive Directors queried whether there would be sufficient time on the agenda in future meetings to discuss all four locality areas, given the level of detail for consideration in the newly formatted Tees report.
Following a three month pilot ending in April 2021, the remaining three Trust localities, (Durham and Darlington, North Yorkshire and York and Forensics) would present their information in the new format, which could be argued would make the agenda quite heavy. (The newly formatted Teesside report had contained 25 pages of information).

There were mixed views of members, some considering having all four present at each QuAC meeting would provide a better opportunity to cross reference across the Trust patch, in terms of the concerning matters of quality and safety, whilst others felt that to give due diligence to the matters for consideration it might be more effective to consider two areas.

Another suggestion was that all four localities be present at each meeting (bearing in mind that the number of QuAC meetings could potentially reduce from the current number of ten per calendar year, pending the GGI review) with three presenting exception reports and one locality presenting the full Quality and Learning report.

The Chairman stated that the March 2021 agenda would remain unchanged, that a separate discussion would take place with the incumbent Chair, Bev Reilly, who would be chairing the Quality Assurance Committee from April 2021.

Mrs Hill left the meeting

2. Future reporting to QuAC

The Director of Quality Governance suggested that it might be helpful to reorder the reports on the agenda with the Trust wide Quality and Learning report featuring first followed by the localities, in order to provide some qualification of the matters that were being reported Trust wide. It would also be

useful to review the reporting timescales from Nursing and Governance to factor in to the schedule for 2021/22 reports from the Sub-Groups to the Committee.

Action: A Lowery

Dr Khouja left the meeting

It was noted that the formal minutes of the last meeting held in December 2020, would be included as an appendices to the Quality Assurance Committee Board report.

Action: D Oliver

20/74 CQC INSPECTION JANUARY 2021

Further to minute 21/09:

Non-Executive Directors reflected on the issues picked up in the recent CQC inspection, which members had not picked up through the QuAC meetings.

The Chairman noted that:

(1) It had been disappointing that the issues had not been picked up by the Trust. In response to the issues that occurred at West Lane Hospital one of the problems identified had been there were unhelpful layers of bureaucracy added to processes.
(2) This had been addressed with immediate effect following the inspection through an RPIW and was being worked through in the CQC action plan.

(3) In response to the pandemic, from March - November 2020 the Committee had operated under "agile" measures with revised terms of refrence, which essentially meant a reduced membership and lighter agenda. Some of the Sub-Groups to the Committee had been suspended, one of which had been the Patient Safety Group, where it might have been expected that patient safety issues would have been picked up.

The Director of Nursing and Governance noted that:

(a) One of the key issues that the CQC had picked up was the need to build into governance systems line of sight on whether patients were safe.
(b) One of the areas of weakness to build upon was the golden thread from Ward to the Board and ultimately the governance review by the Good Governance Institute was anticipated to support and help the Trust make improvements.

20/74 DATE AND TIME OF NEXT MEETING

The next meeting of the Quality Assurance Committee will be held on Thursday 4th March 2021, 2.00pm – 4.30pm via Microsoft Teams.

The meeting concluded at 4.40pm

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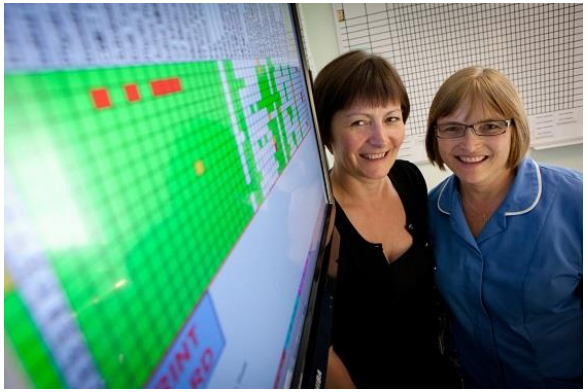
Dr Hugh Griffiths
Chairman



Trust Level Report


Purpose

Appropriate staffing is fundamental to the delivery of safe and effective care. Safe staffing must be matched to patients' needs and is about skill-mix as well as numbers. The purpose of the report is to advise the Board of a 6 monthly review (1st June to 30th November 2020) in relation to nurse staffing (inpatients) as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review) and in line with the NQB Guidance and compliance with Developing Workforce Safeguards (NHSI, 2018).

The report aims to provide the Board with assurance on the key areas of Safe Staffing at a trust level. Statistical process Control (SPC) and triangulation with quality metrics has been used where appropriate to alert the Board to situations and areas where that are of concern, improving or deteriorating.

Executive Summary

The data contained within the 6 Month Safe Staffing Report is correct as at 22nd December 2020. Of the 12 measures identified we have been able to apply Statistical Process Control (SPC) Charts to 14 of these for the period of **1st June to 30th November 2020**. The following key matters are of note:

- At trust level there are 4 measures that are reporting statistically a cause for concern as follows:
  - All of the fill rates with the exception of RN on days are reporting an increase and this is linked to the increase in demand as a result of Covid, staffing pressures etc. The HCA fill rate on nights is presenting statistically a cause for concern across all 4 localities. This is largely because of demand and actual use of staff being deployed above establishments meaning there is often an overreliance on temporary staffing or overtime. Additional staffing has been used throughout the pandemic to meet patient needs.
  - Mandatory training compliance at trust and locality level is reporting a decline; this is linked to the pausing of reporting of this activity and attendance at training not being mandated in order that time can be dedicated to care during the pandemic. This was extended until 31st March 2021 although training is still available albeit on a limited face to face basis.

- There are 4 measures at trust level that are reporting an improvement as follows:
  - Additional duties created with a reason of 'enhanced observations' is reporting a positive reduction at trust level. At locality level the improvement can also be seen in relation to North Yorkshire & York and Teesside. Further work is required to understand the cause for concern within Secure Inpatient Services and this will be addressed through a piece of work aligned to staffing establishments in the service.
  - CHPPD across all 3 measures are reporting an improvement this is linked to a reduction of occupied beds and an increase in staffing as a result of Covid. This is mirrored when reviewing the data at speciality level. The improved position can also be partly attributed to increased staffing through the pandemic including the introduction of 'Aspirant nurses' who joined the Trust as 3rd year students on 'paid placement'. Although, AMH is reporting below the national average, this is being addressed through recommendations outlined in the staffing establishment proposal paper (Trust Board 25th March 2021).
  - This trend has not continued and is unlikely to be seen within the next 6 monthly report due to increased bed occupancy.
  - At a Trust level, bank and overtime are reporting within agreed tolerances.
  - Secure Inpatient Services are the highest users of overtime, have the highest number of red occurrences for RN's on days, have the most incident reports citing staffing levels.

- As part of the surge funding we have taken the opportunity to support 44 Trainee Nurse Associates (TNA's) to commence their training. These posts will be based in community services across the trust. So far 27 nurses have started their course; further candidates are identified for September 2021. We have advertised externally the opportunity to fill the remaining posts. It is anticipated that these NA's will be built into staffing establishments once qualified in the future. Thistle Ward have the highest number of patient safety incidents. Outside of the reporting timeframe for this report, the service has since instituted business continuity arrangements and measures have been taken to collapse wards, seek additional staffing and a clinical review of Thistle Ward is taking place.

There is a noticeably higher agency use in York and N.Yorkshire. This is linked to high vacancies and difficulties in recruiting.

Summary areas identified for action and further development

- The instigation of Mandatory training and trajectories to ensure a sustainable programme can be delivered for 2020/21
- The skill mix of registered to unregistered staff which will be taken forward through the establishment review programme of work and proposals to increase staffing levels on AMH acute and Secure Inpatient Services (SIS)
- Further embedding of roster efficiency across inpatient areas including roster awareness training which is underway
- Continued focus on the delivery of a workforce plan to positively support the retention of staff, recruitment strategies etc.
- Continued work in line with regional and national strategy to address staffing concerns e.g. international recruitment, RN apprenticeships
- Consideration of lessons learned from working through the Covid pandemic
- A review of the trusts 'headroom' is underway to ensure budgets correctly account for time in relation to mandatory training, maternity leave etc.
- Staff wellbeing will be a key feature of the 'Great Place to Work' special interest groups
- Shift patterns are under review following the 12 hour shift research, including a review of a trial to introduce a flexible shift in line with findings that did not have significant uptake
- Surge recruitment is underway in line with projected increases post covid in acuity and demand for mental health services
- Review of patients feeling safe on wards and related actions to improve patient safety

Recommendations

That the Board of Directors note the outputs of the report and the issues raised for further action and development.

Included in this Report

Please note that the data in this report is accurate at the time of production. The issues highlighted may change due to additional information being made available following investigation, resulting in issues being re-categorised.

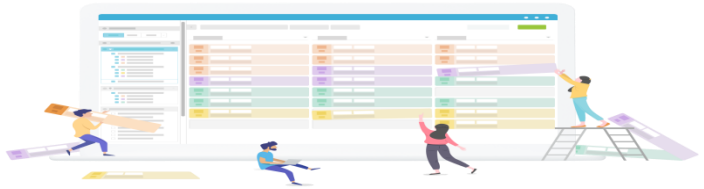
Triangulated Approach to Staffing Decisions	4	• Staffing Establishments	
Right Skills	5	• Mandatory Training Compliance	
Right Place and Right Time	6 - 9	• Fill Rates RN Days and Nights • Fill Rates HCA Days and Nights • Additional Duties	• Bank Usage • Agency Usage • Overtime Usage
Patient Outcomes, People Productivity and Financial Sustainability	10 - 14	• Triangulation with Quality Indicators • Triangulation with Safe Indicators • Breaks not Taken	
Reporting, Investigating and Acting on Incidents	15	• Incidents Citing Staffing Levels	
Patient, Staff and Carer Feedback	16 - 17	• Patient and Carer Feedback • Staff Experience – In our Shoes	
Care Hours per Patient Day	18	• CHPPD	

Summary Dashboard

	Variation	Assurance	Target	Numerator	Denomenator	Rate/%
Additional Duties - enhanced observations	L		-	1354	-	1354
Bank usage !		P	25%	50394	218569	23.1%
Agency Usage !		?	4%	12860	218569	5.9%
Overtime (inc AHPs)		P	4%	7606	218290	3%
Fill rates - RN Day !		?	90%	104862	102368	102.4%
Fill rate - RN Night !	H	F	90%	45933	42186	108.9%
Fill rate - HCA Day !	H	F	90%	151415	120557	125.6%
Fill rate - HCA Night !	H	F	90%	130828	85441	153.1%
Shifts without a break !		F	0	28	61	0.46
Staffing incidents			-	19	-	19.00
Overall CHPPD !	H		-	440018	34438	12.78
RN CHPPD !	H		-	155595	34438	4.52
HCA CHPPD !	H		-	284423	34438	8.26
IIC982: Mandatory training !	L	F	95%	363198	407306	89.2%
% Feel safe on the ward		F	88%	57	95	60.0%

Triangulated Approach to Staffing Decisions:

Staffing Establishments



Analysis (so what)

- Following the MHOST staffing establishment review a report was presented to the Trust Board in February 2020 and agreed the initial priority in regard to the skill mix (registered practitioners to support worker ratio) within the AMH inpatient environment gaining Board support in principle. Since the beginning of the pandemic (March 2020), additional staffing has been used and can be seen within the report, however in order to build safe, high quality sustainable staffing establishments to meet the national guidelines and benchmark figures, a business case is being presented to the Trust Board (24/03/21) setting out initial investment and future plans
- Financial data indicates that the December 2020 position for the contracted clinical staffing levels for inpatient services is higher than reported for the period September 2019 to March 2020 (pre-Covid).
- During Covid we saw increased levels of contracted inpatient clinical staff, ranging from 1,580 WTE in March 2020 to a peak of 1,856 WTE's in July 2020. There has been an increase of 169 WTE's worked from December 2019 (1,947 WTE) and December 2020 (2116 WTE)

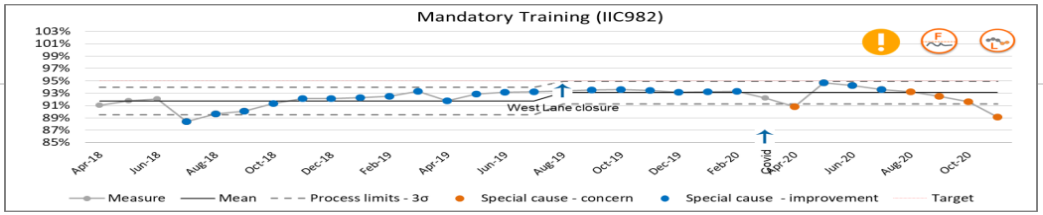
Actions we are taking (now what)

- Surge recruitment is well underway to recruit to additional posts to support increased activity.
- The Finance Sustainability Board and Senior Leadership Group considered the workforce requirements across wards and have supported proposals for an increase in staff in AMH and SIS wards initially across a range of posts and bands
- MHOST and LDOST outputs have been considered, but the data collections over the past two census periods have been impacted by COVID-19, and so are of limited value at this current time. The evidence based tools will continue to be utilised as required by NHSE/I, and further support and training for staff continues to be in place.
- Plans are in place to utilise an evidence based tools for the community services are being considered for rollout later in the year, in conjunction with a pilot in Durham and Preston of a tool for prison based services.

Key Learning and how we are using this

- Identified increased staffing requirements for establishment setting needs on AMH wards to improve patient safety, patient experience and clinical effectiveness.
- Evidence based tools are a key aspect to delivering safe quality care, however further analysis and understanding of the outputs provided continues to be required in this evolving process in the Trust, particularly for those areas where the tool's outputs do not meet the requirements of the staff's clinical and professional judgement.

Right Skills NQB Guidance Adherence



Level	Durham & Darlington	Forensic Services	North Yorkshire & York	Teesside
Variation	L	L	L	L
Assurance	F	?	F	?

Analysis (so what)

- The SPC Charts are reporting this measure as a cause for concern at trust and locality level.
- During Covid the reporting of mandatory training was paused and attendance not mandated to allow operational services to devote their time to care during the pandemic. This has been extended to 31st March 2021. Although training has still been available, some face to face training including Positive approaches and Resuscitation has had reduced numbers due to social distancing requirements

Actions we are taking (now what)

- A review of the headroom is underway to ensure that the correct allocation of time is provided for statutory and mandatory training requirements to be met. Also considered within this review of headroom is the allocation of protected time for registered professional staff to attend to their required training needs for revalidation of their registration.
- Ensuring the effective deployment and oversight of CPD funding and apprenticeships through training needs analysis and workforce analysis.
- Consideration of a 'training academy' to ensure a standardised offer to staff.
- Trajectories are being developed for face to face training with covid safe numbers from April 2021. There is a priority schedule in place to maximise training available.
- The training matrix has been reviewed to prioritise attendance for face to face training for the areas listed above. This is under regular review.

Key Learning and how we are using this

- E-Learning has been developed in relation to Resuscitation, Basic Life Support, CPR, Back Care and Physical Approaches to support ongoing skills development due to the limited capacity to deliver face to face training as a result of Covid restrictions

Nurse Development and initiatives

We are working in partnership with 4 other Mental health trusts, led by South West Yorkshire Foundation Trust, to begin the journey of international recruitment. The focus is on recruitment of candidates who can quickly be supported to join the NMC register. We have agreed to try and recruit 20 staff.

We are working in partnership with Indeed digital recruitment agency and NHSE regional office to be part of the national initiative to have zero HCSW posts by 31.3.2021. In financial terms at a Trust level, we have no actual HCSW vacancies against base line establishments but we have set an ambitious target to over-recruit. This is fast paced work; we have commenced in NY&Y and are offering 12 posts across the locality. We are now working with the other 3 areas of the trust.

We have commissioned Indeed to support the recruitment to the AMH posts identified through the CQC action plan; this includes additional Occupational therapy assistants as well as administrative staff, peer support workers and practice development posts. These posts will support clinical staff to free up 'time to care' as well as promoting a safety culture and embedding organisational learning and supervision.

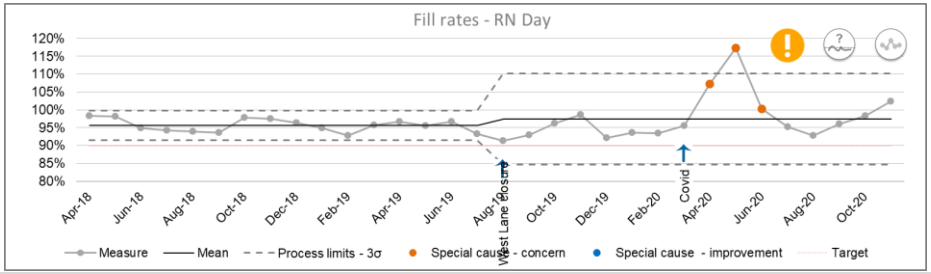
Similarly to last year in the peak of covid where we supported paid placements for student 'Aspirant' nurses, and successfully recruited over 80 registered newly qualified nurses, we are again working in partnership with local university's and have currently placed over 90 final year student nurses in paid placements prior to them qualifying as registered nurses. We are actively fast-track recruiting to attract these staff to the Trust as registered nurses.

As part of the surge funding:

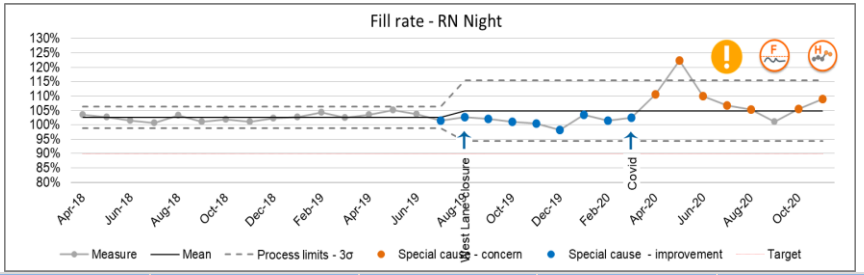
- We have supported 5 new multi-professional Approved Clinicians to training roles whilst in clinical practice. On completion they will work at Consultant level within in-patient services to support Multi-disciplinary clinical leadership
- 29 psychology assistants have been employed by the Trust to enhance the quality of care
- 15 Community Matrons have been appointed to work at advanced practice level to provide clinical leadership to community teams
- 44 Trainee Nurse Associates (TNA's) have been supported to commence their training. These posts will be based in community services across the trust. So far 27 nurses have started their course; further candidates are identified for September 2021. We have advertised externally the opportunity to fill the remaining posts. It is anticipated that these NA's will be built into staffing establishments once qualified in the future.

Right Place and Right Time

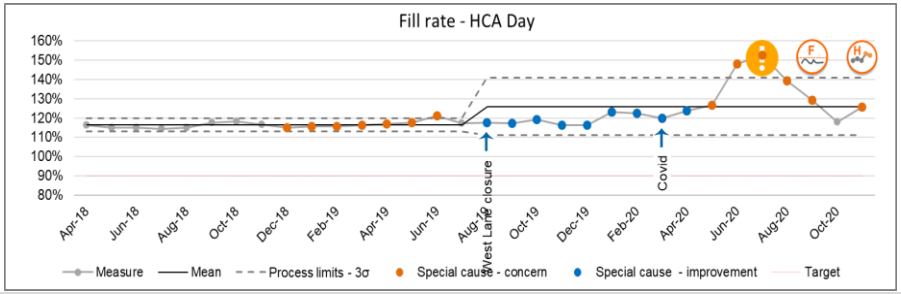
Staffing Fill Rates



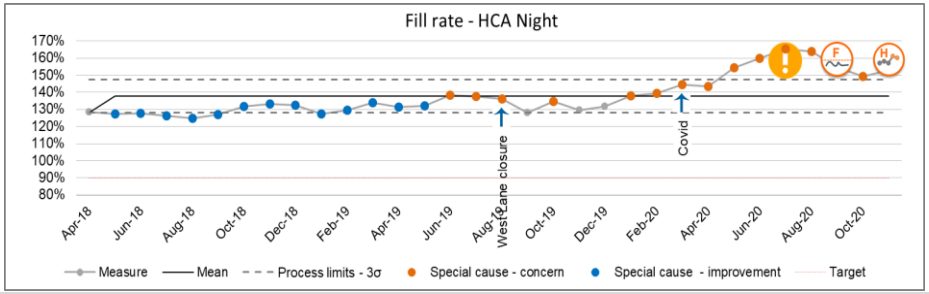
Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation				H
Assurance	?	?	?	F



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation	H		H	
Assurance	F	F	F	F



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation	H		H	
Assurance	F	F	F	F



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation	H	H	H	H
Assurance	F	F	F	F

Right Place and Right Time Continued…

Analysis (so what)

The SPC charts are reporting RN days within a normal variation at trust level with the tolerance of 89.9% being randomly hit/miss. The SPC charts at locality level are reporting a cause for concern in relation to Teesside, although this actually means that there was a higher level of registered Nurses on duty than was planned which would have positive impact on the level of care for patients.

- In terms of RN on nights the SPC chart is reporting at trust level a cause for concern with the tolerance of 89.9% consistently failing to be achieved. At locality level Durham & Darlington and North Yorkshire & York are reporting a cause for concern.
- In terms of HCA on Days the SPC chart is reporting at trust level a cause for concern with the tolerance of 89.9% consistently fails to be achieved. At locality level a cause for concern has been highlighted with regards to Durham & Darlington and North Yorkshire & York.
- The SPC Chart for HCA on Nights is reporting a cause for concern at trust and locality level.

- The 6 monthly position in terms of the average fill rates for RN's shows that there were 22 (34.9%) fill rates of less than 89.9% (shown as red) for registered nurses on daytime shifts and 9 (14.3%) for registered nurses on nights. The 6 monthly position in terms of the average fill rates for HCA's shows that there were 10 (15.9%) fill rates of less than 89.9% (shown as red) for HCA on daytime shifts and 5 (7.9%) for HCA on nights.
- This shows that although the trust usually meets its planned staffing numbers there is, on occasion, a deficit of the planned skill mix from registered to non-registered. This presents risks as it limits the quality and safety of interventions that can be offered from a registered nursing perspective. We are aiming to improve this with proposed investment in registered nursing posts and the focus on recruitment and retention.
- Secure Inpatient Services have the highest number of red occurrences (11 wards) across the reporting period for RN on days and Teesside have the highest number of red occurrences for HCA on both days (5 wards) and nights (3 wards).
- Focussing on the top 3 lowest average fill rates these were in relation to Oak Rise for HCA on Days equating to 60.5%; Newtondale in relation to RN on Nights equating to 61.2% and Wold View in relation to RN on Days equating to 63.4%.
- The highest average fill rates were in relation to Bedale Ward for HCA on Nights equating to 367%; Tunstall for HCA on Nights equating to 281.9% and Cedar (D&D) for HCA on Days equating to 277.6%.

Actions we are taking (now what)

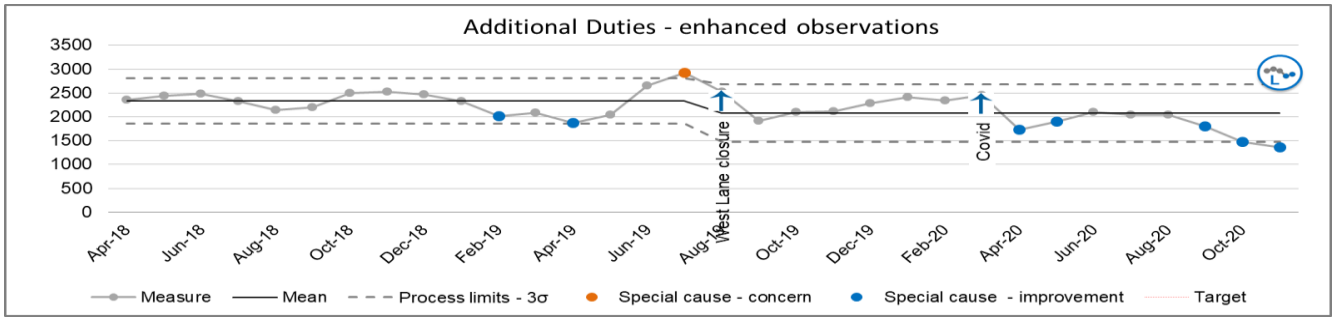
- The registered practitioner and support worker skill mix deficits have been reported to the Finance Sustainability Board and Trust Board for consideration of achieving funding to support redressing the difference in the current skill mix levels and benchmark values.

Key Learning and how we are using this

- This metric helps the Trust determine whether its planned staffing is sufficient to meet clinical need and demand. Along with CHPPD, it can indicate where additional investment in staffing establishments may be required.

Right Place and Right Time Continued…

Additional Duties



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation		H	L	L

Analysis (so what)

- This measure is looking at the number of additional duties that have been created over and above the budgeted establishment with a reason of 'enhanced observations'.
- The SPC chart at trust level is reporting this measure within a special cause variation (improvement) at trust level. The improvement could be linked to a reduction in bed occupancy during Covid but especially at the outset of the pandemic. At locality level a special cause variation (cause for concern) is evident within Secure Inpatient Services.
- The number of additional duties created with a reason of enhanced observations ranges from 1,354 to 2,100 duties a month over the 6 month period. In total 117,769.60 hours were created which would equate to 9,814 12 hour shifts.
- The highest creators of additional duties were Westerdale South (Teesside), Harrier/Hawk (Secure Inpatient Services) and Mallard Ward (Secure Inpatient Services)

Actions we are taking (now what)

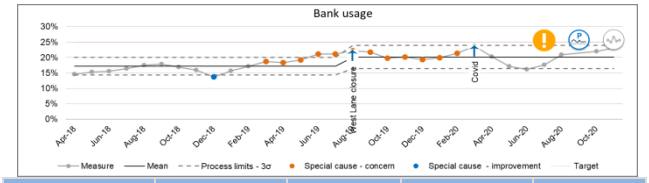
- The Zonal model of care, used at Westerdale is reported to continue to provide positive quality and safety benefits due to seeing a sustained reduction in the number of falls in addition to an increased staffing resource to support activities and leave for patients in the local area, but utilises an increased staff usage. Formal evaluation is anticipated in the coming period to consider utilising this care model on other inpatient wards.
- Ongoing roster awareness training to support correct and effective rostering
- SIS have a minimum of a daily review of staffing across the site and allocation of staffing to meet patient need. This includes the use of senior staff to support activities and breaks on the wards.

Key Learning and how we are using this

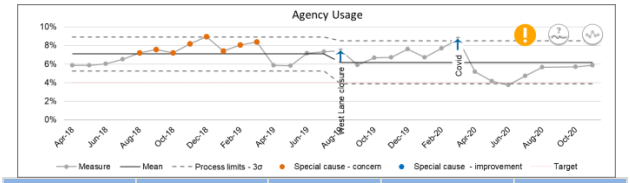
- Additional duties for observations as well as acuity and complexity scores are used as part of the professional judgement approach to reviewing safe staffing establishments. Further consideration is to be given about the feasibility of the zonal approach to care and how this might be used with SIS.

Right Place and Right Time Continued…

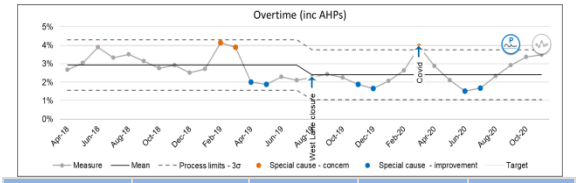
Bank, Agency and Overtime Usage



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation				
Assurance	P	?	P	P



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation		Not enough data for SPC		
Assurance	?	N/A	F	?



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation				
Assurance	P	?	P	?

Analysis (so what)

- The SPC charts for Bank, agency and overtime are all reporting within a normal variation at trust and locality level.
- The highest users of bank as a proportion of the actual hours worked (over 25% usage) were Kestrel/Kite (44.8%); Brambling (35.6%) and Harrier/Hawk (35.6%) within SIS. 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.
- Nursing and medical agency expenditure accounts for 93% of total agency expenditure and is used to support vacancies and enhanced observations with complex clients. Recruitment options are being explored to reduce dependency on agency further and progress continues to inform conversations with NHSI.
- The highest users of agency as a proportion of the actual hours worked (over 4%) were Springwood (18.3%); Wold View (17.2%) and Bedale Ward (17%). There is a noticeable higher use in the North Yorkshire and York locality, it is recognised that this impacted on by the ability to recruit in that area as well as the limited availability of bank staff and higher staff turnover.
- The highest users of Overtime (over 4%) of the actual hours worked were Holly (9.9%); Bek/Ramsey (6.4%) and Bankfields Court (6.1%). Secure Inpatient Services are using the most overtime (10,642 hours) whilst North Yorkshire & York are using the least (6,088 hours).
- A total of 31 wards have utilised bank, agency and overtime within the reporting period.

Actions we are taking (now what)

- The localities continually review the use of bank and agency usage as part of their ongoing roster management and any concerns are escalated through to their daily huddles and to their governance groups.
- This information has been used to support and inform the staffing establishment review process to understand and agree the future staffing levels moving forward.

Key Learning and how we are using this

- Ensure that the budgeted establishments within the electronic system are up to date and are accurate.
- Work continues to align the planned / budgeted staffing levels to meet patient need and reduce the demand on temporary staffing services.
- Continue to build the bank staff capability hosted within the trust which in turn would minimise the requirement for agency and overtime in the future.

Patient Outcomes, People Productivity and Financial Sustainability

Triangulation with Quality Indicators

Quality Indicator				Ward Name	Bank Usage	Agency Usage	Actual staff rostered			
SI's	L4	L3	Complaints				RN Days	RN Nights	HCA Days	HCA Nights
1	0	3	0	Ebor Ward	24.3%	12.9%	110.3%	109.8%	134.2%	199.5%
1	0	1	0	Farnham Ward	21.4%	11.2%	118.8%	137.8%	185.5%	215.5%
1	1	0	2	Maple	27.2%	5.7%	86.4%	107.1%	202.2%	196.3%
1	0	7	0	Overdale	14.0%	9.6%	118.6%	102.5%	184.1%	196.9%
1	1	6	0	Thistle	30.3%	0.0%	77.8%	101.2%	118.9%	133.3%
1	0	0	0	Bek-Ramsey Ward	8.7%	4.4%	99.5%	131.9%	104.9%	127.6%
1	1	0	0	Oak Ward	12.0%	1.4%	95.1%	105.3%	130.5%	124.9%
1	1	0	0	Roseberry Wards	6.4%	0.4%	102.1%	110.5%	109.0%	107.7%
2	1	0	1	Westerdale South	14.3%	11.4%	94.1%	76.1%	148.5%	225.7%
0	1	0	1	Danby Ward	18.4%	7.3%	108.9%	103.5%	171.1%	144.2%
0	0	2	0	Esk Ward	16.1%	3.3%	89.0%	99.7%	174.2%	154.0%
0	0	6	0	Bedale Ward	34.2%	17.0%	93.5%	97.1%	222.4%	367.0%
0	0	1	0	Cedar	31.2%	8.1%	101.7%	96.5%	277.6%	202.7%
0	0	3	2	Elm Ward	33.4%	6.8%	100.7%	118.1%	175.4%	201.0%
0	0	1	1	Lustrum Vale	24.9%	0.3%	110.1%	101.1%	117.7%	110.6%
0	0	2	1	Tunstall Ward	25.3%	13.9%	91.4%	136.6%	222.9%	281.9%
0	0	1	0	Clover / Ivy	28.4%	0.0%	109.8%	103.3%	86.4%	141.2%
0	0	1	0	Thornaby Road	3.5%	0.0%	81.5%		176.6%	104.1%
0	0	0	2	Bilsdale	22.1%	8.2%	110.4%	110.9%	153.7%	206.1%
0	0	0	2	Birch Ward	28.0%	2.5%	82.8%	100.5%	212.2%	212.8%
0	0	0	1	Bransdale	27.1%	15.8%	100.9%	101.7%	177.6%	267.4%
0	0	0	4	Minster Ward	27.3%	14.1%	86.8%	198.1%	143.6%	213.9%
0	0	0	3	Stockdale	33.2%	7.2%	92.1%	103.3%	180.3%	196.5%
0	0	0	3	Harrier/Hawk	35.6%	0.0%	95.1%	106.6%	122.3%	223.0%
0	0	0	1	Kestrel / Kite.	44.8%	0.0%	87.6%	108.6%	148.9%	207.4%
0	0	0	2	Northdale Centre	31.9%	0.0%	87.6%	103.9%	109.9%	145.9%
0	0	0	1	Lark	13.4%	0.0%	88.2%	108.3%	123.4%	102.0%
0	0	0	1	Nightingale	13.2%	0.0%	92.3%	107.5%	111.9%	101.2%
0	0	0	2	Westerdale North	18.6%	12.2%	113.1%	131.7%	124.0%	158.9%

(There were no incidents recorded from Bilsdale - Westerdale North)

Patient Outcomes, People Productivity and Financial Sustainability Continued…

Triangulation with Quality Indicators continued….

Analysis (so what)

- This section explores all serious incidents, severe harm incidents (L4); self-harm incidents of moderate harm (L3) and all complaints raised within the 6 month reporting period.
- Patient Safety investigation team have been asked to specifically consider staffing levels and skill mix in relation to their investigation of inpatient SI's to support more robust triangulation of staffing data and aid root cause analysis. During the reporting period there was 1 case reviewed at Directors Panel which highlighted either a root cause or contributory finding regarding staffing as follows:
  - The experienced staff were all fully aware of decision making processes related to patient care and are aware of the items patients can and can't have access to however, staff with less experience were not fully trained in processes and therefore had a reduced understanding of items patient could access
- It is clear from the recent staffing establishment review (professional judgement approach) that whilst staffing levels may not have been seen to directly contribute to a patient safety incident that patient acuity, complexity and bed occupancy is felt to be a pressure in relation to clinical activity and the delivery of quality care across a number of units.
- None of the complaints raised cited issues with staffing levels or skill mix. However there were 5 complaints that did raise concerns with regards to staff attitude (2 X Harrier, 1 X Danby, 1 X Northdale and 1 X Birch)

Actions we are taking (now what)

- Wider themes relating to serious incidents and complaint data are analysed further through the weekly Quality and Safety Cell along with any actions needed for further investigation.
- The staffing skill mix will be reviewed where we are reporting below the tolerance of 89.9% and will be included in the staffing review analysis.
- Analysis and triangulation take place within the localities to identify and themes or areas of learning that need to be actioned key risks and actions to are then reported to QUAC for trustwide consideration, learning and action if required

Key Learning and the actions we are taking

- As the pandemic has continued we have seen an unprecedented need to increase staffing to cover staff absences and increase in acuity
- In order to free up staffs time to care and focus on a safety culture, establishment reviews have focussed on additional roles to support inpatient clinical activity and improve the RN/HCA skill mix ratio

Patient Outcomes, People Productivity and Financial Sustainability Continued…

Triangulation - Safe Indicators

Quality Indicator			Ward Name	Bank Usage	Agency Usage	Actual Staff Rostered			
Falls Harm	Pressure Ulcers	Medication Errors				RN Days	RN Nights	HCA Days	HCA Nights
1	0	8	Roseberry Wards	6.4%	0.4%	102.1%	110.5%	109.0%	107.7%
2	0	0	Westerdale South	14.3%	11.4%	94.1%	76.1%	148.5%	225.7%
0	2	0	Birch Ward	28.0%	2.5%	82.8%	100.5%	212.2%	212.8%
0	1	0	Overdale	14.0%	9.6%	118.6%	102.5%	184.1%	196.9%
0	1	0	Mallard	28.8%	0.0%	102.0%	142.0%	151.4%	180.4%
0	1	6	Oak Ward	12.0%	1.4%	95.1%	105.3%	130.5%	124.9%
0	3	7	Rowan Lea	14.1%	11.3%	114.4%	99.5%	269.4%	181.1%
0	2	9	Wold View	13.8%	17.2%	63.4%	158.9%	115.9%	138.7%
0	0	13	Springwood	18.6%	18.3%	90.5%	101.7%	232.4%	235.0%
0	0	13	Westerdale North	18.6%	12.2%	113.1%	131.7%	124.0%	158.9%
0	0	11	Mandarin	10.6%	0.0%	84.2%	101.8%	108.6%	102.1%
0	0	14	Farnham	118.8%	137.8%	185.5%	215.5%	185.5%	88.05%
0	0	12	Elm	100.7%	118.1%	175.4%	201.0%	175.4%	86.61%
0	0	11	Ebor	110.3%	109.8%	134.2%	199.5%	134.2%	71.43%
0	0	11	Maple	27.2%	107.1%	202.2%	196.3%	202.2%	85.42%
0	0	10	Bedale	93.5%	97.1%	222.4%	367.0%	222.4%	83.91%
0	2	9	Wold View	63.4%	158.9%	115.9%	138.7%	138.7%	71.61%

Analysis (so what)

- There were 3 incidents recorded as falls that resulted in significant harm within inpatient services. All of the falls occurred within older people's service.
- There were 10 incidents reported in relation to pressure ulcers. Again the majority of these occurred within older people's service.
- There were 312 incidents of medication errors reporting within the reporting period across 55 wards. The top 10 wards for medication errors are listed within the data set above.

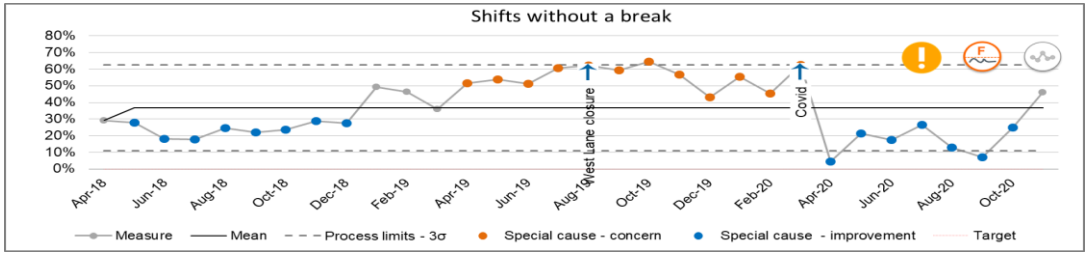
Actions we are taking (now what)

- A review is undertaken where all falls have occurred that have resulted in significant harm a review of the clinical practice against the standard is carried out to ensure that any learning is taken forward.
- All pressure ulcers are reported through to the Physical Health Team using Datix, further information is obtained from the ward or if needed a visit is arranged. If a pressure ulcer is categorised as a category 3 or 4 this is classified as a Serious Incident. The pressure ulcer procedure has recently been updated which is more in depth regarding when risk assessments and skin assessments should be completed and when to submit a Datix incident.
- All medication errors are reviewed weekly, and significant concerns are discussed in the Quality and Safety Cell. The trusts existing Medicines Safety Series documents are being updated. We are proactively informing the MSO on acute Trusts for transfer of care incidents, where the error lies with the acute trust, to try to resolve these from occurring. We are doing a deep dive of depot incidents to see if there any trends and any learning which can be taken from incidents recently reported.

Key Learning and how we are using this

- Key learning from medication incidents focussed on wrong patient errors. An Information Governance request to commence the introduction of photographic identification of patients onto prescription and administration records on admission as the first choice option with wristband identification being the second choice option has been made. We are awaiting a decision in terms of the preferred option.
- Following a recent SI for a pressure ulcer the learning from this identified the need to implement training on pressure ulcer prevention and how to complete the Waterlow Pressure Ulcer Risk Assessment chart and body map skin assessment chart. This work is currently ongoing.

Breaks not Taken



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation		L		
Assurance		F		

Analysis (so what)

- The SPC Chart is reporting within a normal variation at trust level. In terms of locality level Secure Inpatient Services are reporting an improvement whilst all other localities are reporting within a normal variation. An increase in staff breaks has coincided with reduction in bed occupancy and or patient activity.There were 1,377 shifts worked within the reporting period where breaks were not taken
- The top 5 wards were Kestrel/Kite (100 shifts); Elm Ward (88 shifts); Bedale Ward (71 shifts); Thistle (68 shifts) and Brambling Ward (67 shifts).
- The majority of shifts where breaks were not taken occurred on day shifts and are reported by the services as being due to periods of high clinical activity or staffing shortfalls to meet demand.

Actions we are taking (now what)

- The absence of breaks is monitored by localities in order to reinforce the importance of ensuring breaks are taken during the course of a shift.
- Ensuring there is appropriate escalation in place and using additional staffing to support breaks to be taken

Key Learning and how we are using this

- Continued education with regard to ensuring the staff Health Roster is properly maintained and updated to record all occurrences of missed breaks and the reasons why breaks are not being taken.
- Triangulation with other metrics to identify wards with high acuity and staffing pressures Staff wellbeing aspects are being fed into the “Great Place to Work” Special Interest Groups for consideration.

Reporting, Investigating and Acting on Incidents Citing Staffing Levels

Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation	L	H	L	L

Analysis (so what)

- The SPC Charts are reporting this measure within a normal variation at trust level. At locality level Secure Inpatient Services are reporting within a special cause variation (cause for concern) whilst the other localities are reporting an improvement.
- There were 108 incidents raised citing issues with staffing. This is a decrease of 19 when compared to the previous 6 month report.
- Of the total incidents reported 22 were in relation to day shifts and 86 were reported in relation to nights from 19 teams across the Trust
- 82% (88) of all staffing incidents reported involved the Secure Inpatient Services Wards at Roseberry Park
- 98 incidents were reported for inpatient areas whilst there were 10 reported involving community services.
- Themes include - Enhanced observations increasing staffing requirements, Insufficient FFP3 trained staff on duty to provide Covid response, Wards not running on required staffing levels / skill mix, staff sickness – long and short term, Covid related absence due to sickness, isolation and quarantine, high acuity, ratio of agency/bank staff to permanent staff, lack of capacity to meet increasing demand of the service and service delivery and business continuity plan implemented on 7 occasions

Actions we are taking (now what)

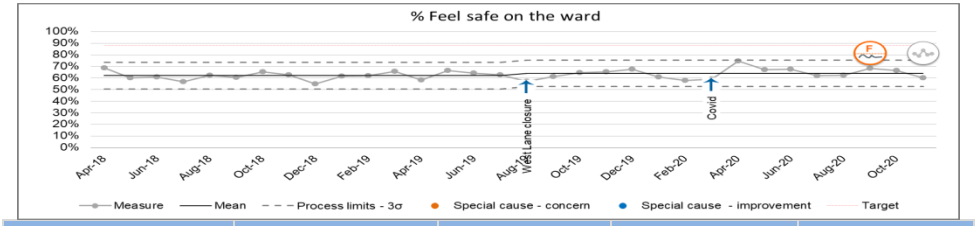
- Using the establishment review process and focus on recruitment to increase the registered practitioner to support worker skill mix on AMH acute and Secure Inpatient services wards to meet recommended levels as detailed by evidence based staffing tools, professional judgement and benchmarking.

Key Learning and how we are using this

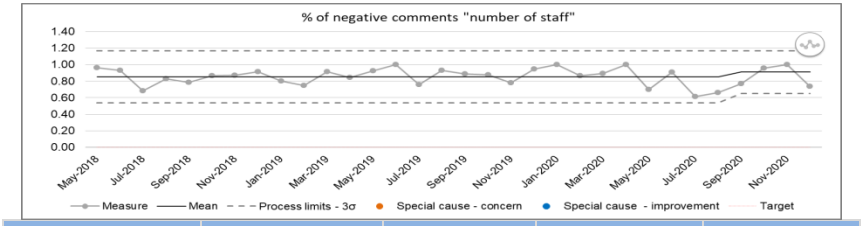
- Locality Heads of Nursing review staffing incidents and data for themes, triangulation to inform staff morale and well-being, culture and leadership of teams.

Patient, Staff and Carer Feedback

Patient and Carer Feedback



Level	Durham & Darlington	Forensic Services	North Yorkshire & York	Teesside
Variation				
Assurance	F	F	?	F



Level	Durham & Darlington	Forensic Services	North Yorkshire & York	Teesside
Variation			L	L

Analysis (so what)

- 145 comments were received from our patient experience surveys that suggested improved staffing was required within our inpatient wards due to a perception that staff are stressed with their workloads and to support further activities including supporting leave, continuity of care and overall quality care and safety of patients.
- From the total number of 272 compliments, there was nothing highlighted that was specific to staffing levels.
- The SPC chart at trust level in relation to feeling safe is reporting this metric within a normal variation however; the target of 88% consistently fails to be achieved. A similar picture can also be seen at locality level. The reasons given by the patients were "*I didn't really let you know how I really felt, having witnessed incidents, unfamiliar surroundings, under staffed, patients were shouting and arguing, atmosphere of fear and not being able to help people, probably mainly due to my mental health"*
- 74% of the comments relating to the number of staff available were negative (community and inpatient). The SPC chart at trust level is reporting this within a normal variation and at locality level North Yorkshire & York and Teesside are reporting an improvement. An example of the comments received by patients included *"more staff would be great as staff never stop; the actual service when it happened was excellent but the delay in being seen was unacceptable; staff have fully supported son and he looks like a different lad thank you so much; more care co-ordinators"*

Actions we are taking (now what)

- Consideration of feedback in staffing establishment setting exercises
- Consideration of the broader implications in terms of developing a patient safety culture feeling safe has been identified as a priority within the Quality Account. The actions include identifying problem areas and developing an action plan; complete training of drug detection dogs, undertake work to improve liaison with the Police; monitor the pilot of body cameras;

Key Learning and how we are using this

- Feedback outcomes into Special Interest Groups, such as “A Great Place to Work”, and the Trust Workforce sub-group of SLG to support future strategic planning regarding staffing and workforce
- Triangulation in workforce planning and establishment reviews
- Our patients have advised that they do not feel safe due to the increased use of drugs and other illicit substances on our inpatient wards, actions have been highlighted as above to reduce these risks

Patient, Staff and Carer Feedback Continued…

Staff Experience – in our shoes

The staff team from Bek/Ramsey Ward were asked to share their experience of working during Covid:

So for me being a student and then qualifying during the pandemic has been quite surreal! The transition from aspirant nurse into qualified was massive.

Wearing the constant PPE was a struggle but you learn to adapt to it as there is no other choice.

Nursing a patient that had contracted Covid made me realise how important my staff team were. Everyone felt the angst and upset; however the whole team pulled together and were able to support each other amazingly.

I think we have worked well as a team during this pandemic but staff are still confused with the Covid rules i.e. told we couldn't car share or travel with other people

I feel confused as we are getting told one thing and doing another no consistency with the government restrictions.

The adjustment to working from home has been challenging but this allowed me to continue to support the team. However, I have felt guilty not being there. I miss seeing people every day.

Getting stock has been difficult and uniforms have been a major issue and very time consuming, having to place countless orders and staff complaining about sizing/colour. The heating in all areas was unbearable and made working in PPE difficult.

During the pandemic I moved from the community team to the ward, the staff team have been amazing and extremely supportive.

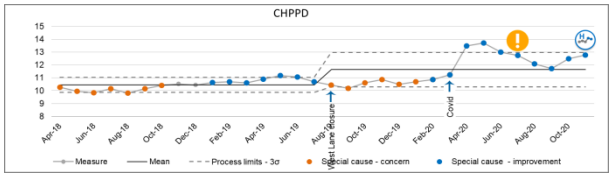
The staff team have been very imaginative and creative keeping the service users busy and entertained e.g. posters, karaoke, quizzes, ping pong, BBQ's and sports

I feel that pressures have increased on all staff and accessing training has been difficult; hope that more time is given to accessing training when it becomes available

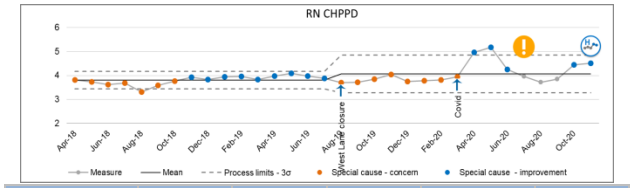
Those staff who had to isolate felt guilty for not being at work or working at all (no fault of the Trust). I have felt awkward when asking staff to vacate an area due to Covid risk.

I have really struggled with wearing the mask, as my asthma symptoms tend to increase and my asthma has worsened since having Covid

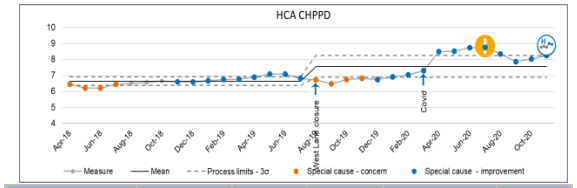
Care Hours per Patient Day (CHPPD)



Level	AMH	CYP	LD	MHSOP	SIS
Variation	H	H	H	H	H



Level	AMH	CYP	LD	MHSOP	SIS
Variation		H	H		H



Level	AMH	CYP	LD	MHSOP	SIS
Variation	H	H	H	H	H

Analysis (so what)

- The SPC Chart is reporting this measure within a special cause variation (improvement) at trust level. In terms of speciality the charts are reporting overall an improvement with the exception of RN CHPPD for AMH and MHSOP who are reporting within a normal variation.
- This metric tracks the total number of direct nursing care hours compared to the number of patients as a count at midnight. The average CHPPD across all inpatient areas was 11.6 WTE (4.0 WTE registered nurses; 7.37 WTE healthcare assistants; 0.17 WTE registered AHP; 0.09 WTE unregistered AHP).
- In terms of AMH we are reporting under the national average.

Actions we are taking (now what)

- Included in establishment review reports for AMH inpatient services to support triangulation for increasing staffing establishments.
- Develop a briefing/teaching document for all ward based staff regarding CHPPD to increase its visibility and uses, including access to Model Hospital.
- Local TEWV dashboard on IIC for CHPPD.
- Consider CHPPD broken into sub-specialities
- The fill rates are monitored locally on a monthly basis and reported to NHSE as per national requirements

Key Learning and how we are using this

- Benchmarking against peer and national Trusts using Model Hospital
- Benchmarking against local wards of same speciality / sub-speciality
- Variation between wards within a speciality needs to be reviewed at a more granular level.

Appendix 1

SPC Symbols

Variation:

Special cause variation – cause for concern
(indicator where high is a concern)

Special cause variation – cause for concern
(indicator where low is a concern)

Special cause – improvement
(indicator where high is good)

Special cause variation – improvement
(indicator where low is good)

Common cause variation

The data does not meet the assumptions of the normal distribution and the SPC chart should be interpreted with caution

Assurance:

Consistently hit target

Hit and miss target randomly

Consistently miss target

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 12

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Thursday 25th March 2021**
TITLE:	**Proposal for staffing establishments**
REPORT OF:	**Elizabeth Moody**
REPORT FOR:	**Information and Approval**

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

Executive Summary:

Further to a more detailed paper presented to the Financial Sustainability Board on the 17th February 2021 and subsequent reports to the Senior Leadership Group for Adult Mental Health (AMH) and Secure Inpatient Services (SIS), this paper focuses on the immediate investment required for AMH acute wards and PICU's together with SIS wards, to support the delivery of safe care and enhance quality assurance and clinical practice standards in line with the Trusts CQC action plan.

Previously, there has already been specific work undertaken by the Trust to address staffing establishments which has been shared at Board and CCG level (via Quality Boards). This identified some variation in skill mix and made recommendations to change over time the ratio of qualified to unqualified staff.

The Trust is required to use evidence based tools (MHOST) to support professional judgement in achieving the correct staffing establishments based upon acuity and dependency of the patients. Recent MHOST data collections, March 2020 and more specifically September 2020, have been significantly impacted by COVID-19 due to either an incomplete assessment period or reduced bed occupancy, both of which would provide an inaccurate perspective of the ward for this period.

The continued staffing pressures due to COVID-19 have been a contributing factor to some wards across the Trust not being able achieve the full set of acuity scores for the assessment period, and as such has impacted the validity and reliability of the results. It is anticipated that there may be continuing issues moving into March 2021 based upon some early conversations and feedback, and so further methods of support are being discussed

and considered for the 2021 assessment periods

Whilst the focus is on staffing establishments, “invest to improve” initiatives will ensure safer and more effective care can be provided and may also deliver significant productivity and financial savings by freeing up time to care which include a pilot of a zonal model of care and engagement, acuity based rostering, the use of a digital care assistant, admin reviews to support the provision of an increase in the clinical time available to clinical staff, and the development of evidence based tools outside of the inpatient setting. The expectation and requirement of these developments is to increase the quality of care and patient safety within the Trust and to improve upon staff well-being and staff retention. These developments also extend to community teams where it is identified that they will supplement and support the current ongoing work underway on the community mental health framework.

Recent work in the Trust has informed the recommendations set out below for immediate investment in AMH admission wards and PICU as well as Secure Inpatient Service wards.

Failure to consider and ensure the correct baseline establishment in staffing calculations can lead to reliance on temporary and agency staff, reduced compliance with statutory and mandated training, staff burnout, and recruitment and retention difficulties. These will challenge quality of care and patient safety and experience. As such the overall expectation is to provide a positive impact upon the following areas:

- Time to care – releasing nursing staff time to care
- Leadership and culture
- Enhance quality focus and skill mix
- Enhance patient experience and reduce incidents
- Support workforce development and retention
- Reduce the use of bank staff and reliance on overtime
- Reduce existing staffing overspend

The paper identifies the immediate staffing priorities and details proposed investments on a ‘safe today, safe tomorrow’ basis, as well as setting out a plan and timescales of staffing establishment reviews across inpatient services based on a multi-professional model and using Care Hours Per Patient Day to inform rosters.

Recommendations:

That the Trust Board note the content of the report and consider what action is needed and:

- To provide additional funding as detailed to meet the immediate staffing priorities for the AMH admission / PICU wards and Secure Inpatient Services as outlined in the paper.

- To approve the plan and timescales for further consideration of staffing establishments in the remaining inpatient ward areas.

MEETING OF:	**Board of Directors**
DATE:	**Thursday 25th March 2021**
TITLE:	**Staffing Establishments**

1. INTRODUCTION & PURPOSE:

1.1. Further to a more detailed paper presented to the Financial Sustainability Board on the 17th February 2021 and subsequent reports to the Senior Leadership Group for AMH and SIS, this paper focuses on the immediate investment required for AMH acute wards and PICU's together with SIS wards, to support the delivery of safe care and enhance quality assurance and clinical practice standards in line with our CQC action plan.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1. Failure to consider and ensure the correct baseline establishments in staffing calculations can lead to reliance on temporary and agency staff, reduced compliance with CQC fundamental standards, staff burnout, and recruitment and retention difficulties. These will challenge quality of care, patient safety and experience.

2.2. The delivery of safe and clinically effective care can be directly correlated to having the appropriate and required proportion of Registered Practitioner's (RP) multidisciplinary staff to Healthcare Support Worker staff (HCSW). Whilst Griffiths et al (2019) acknowledge the importance of the role HCSW's play in maintaining safety of hospital wards, it is stated emphatically that they cannot act as substitutes for registered staff, and highlight the potential consequences and negative impacts on patient safety should this occur. It is further concluded that "the adverse consequences of Registered Nurse (RN) shortages are unlikely to be remedied by increasing the numbers of lesser trained nursing staff in the workforce".

2.3. In response to the recent CQC inspection and warning notice, the Trusts action plan sets out an immediate and pressing need to explore ward staffing and skill mix to ensure there are the right skills and expertise to support safe delivery of care and enhance quality assurance, clinical leadership and practice development standards at ward level.

2.4. Whilst the immediate focus is on staffing is to support safety on the AMH admission wards and PICU, it is acknowledged that there are other areas of investment required to support quality of care issues across other inpatient specialties in the medium term. This will include developing Care Hours Per Patient Day (CHPPD), to move away from a registered to unregistered nursing spilt to include AHP's and therapies. A plan is set out below with timeframes for consideration of these.

2.5. There is also a need for the Trust to consider baseline staffing establishments in the round alongside other initiatives that may release or support time to care on our wards including the use of technology such as the Oxehealth Digital Care Assistant or how we use our staff resources to support care, shift patterns, rostering etc.

3. **KEY ISSUES:**

3.1. The Trust is required to use evidence based tools to support professional judgement in achieving the correct staffing establishments based upon acuity and dependency of the patients.

3.2. There has already been specific work undertaken by the Trust to address staffing establishments which has been shared at Board and CCG level (via Quality Boards). This identified some variation in skill mix and made recommendations to change over time the ratio of qualified to unqualified staff.

3.3. There are known pressures in some areas around vacancies and retention issues and the clinical leadership on some wards as a consequence of this.

3.4. The use of agency and bank can be high reflecting recruitment difficulties and/or enhanced observations on the wards. Where the registered nursing skill mix cannot be met, this is often covered by non-registered bank or agency staff, further depleting the registered skill mix.

3.5. Recent MHOST data collections, March 2020 and in more specifically September 2020, have been significantly impacted by COVID-19 due to either an incomplete assessment period or reduced bed occupancy, both of which would provide an inaccurate perspective of the ward for this period. The continued staffing pressures due to COVID-19 have been a contributing factor to some wards across the Trust not being able achieve the full set of acuity scores for the assessment period, and as such has impacted the validity and reliability of the results. It is anticipated that there may be continuing issues moving into March 2021 based upon some early conversations and feedback, and so further methods of support are being discussed and considered for the 2021 assessment periods

Adult Admission Wards

3.6. Adult admission wards have generally shown to be the most aligned with the MHOST outputs over previous census periods, and in general, this remains a reasonable assertion based upon the recent results.

3.7. The national Care Hours Per Patient Day (CHPPD) metric on the Model Hospital database shows TEWV Adult Mental Health wards below both the Peer Trust median and the National median values (see figure 1 where TEWV = “My Trust”). Please note that Adult Mental Health category in Model Hospital includes AMH, Rehab, and Eating Disorders, and so their median values are a combined average. Appendix 1 shows TEWV PICU wards on average for the pre-covid period to be just above the peer and national median values.

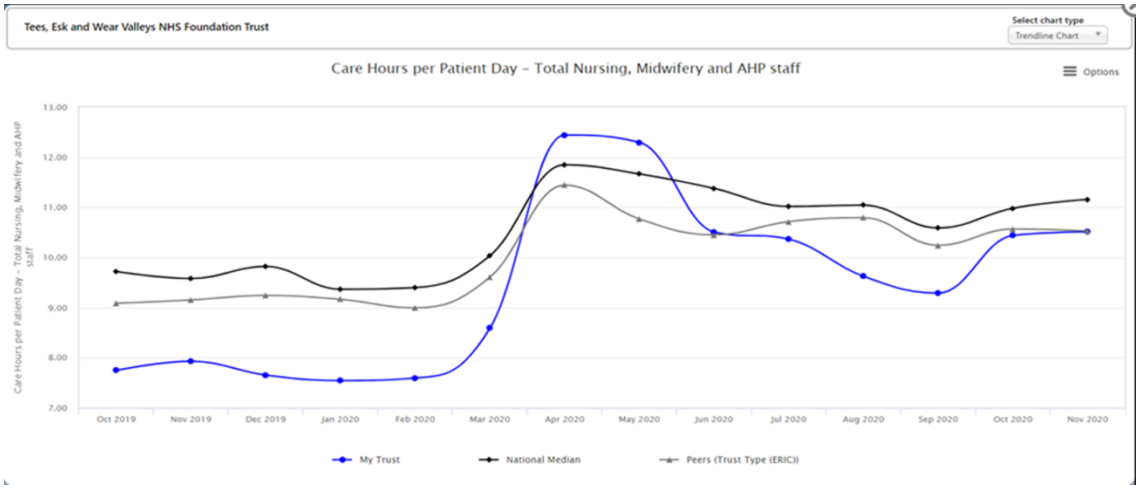


Figure 1 Model Hospital – National view of CHPPD for AMH

3.8. Evidence shows that using unregistered staffing to supplement staffing shortfalls can lead to detrimental patient outcomes and can impact on effective clinical leadership and the culture. In general the current RP to HCSW ratios for the AMH wards under review are under the benchmark values and are impacted further still by the increased use of additional and temporary unregistered staff.

3.9. The skill mix of staff upon the wards remains an issue in general across all wards, which will be impacted by the use of flexible staffing which are generally filled by unregistered nursing staff on the inpatient wards. The skill mix of registered practitioner (RP) to health care support worker (HCSW) in respect to the budgeted clinical staffing establishment of 50.22% for AMH A&T wards is below the MHOST benchmark of 54% for Acute Admission wards. However, further analysis shows that the RP% actually worked on the wards is significantly lower at 33.8%. PICUs budgeted skill mix of 52.4% is currently above the 48% benchmark.

<u>Secure Inpatient Services – Low Secure Units (LSU) & Medium Secure Units (MSU)</u>

3.10. At this current time, it is seen that in general the MHOST results for Secure Inpatient Services do not support the professional judgement of the clinical services in regard to the current staffing requirement and need on the majority of the SIS wards.

3.11. Recent developments have CNTW and TEWV moving to establish a Provider Collaborative (PC) model for secure inpatient and community services for the NE population, which will see the Collaborative contracting with TEWV and other providers in the UK for this service provision.

3.12. TEWV and CNTW will work together in terms of priorities and developing services to meet the service user's needs. The PC will enable the two Trusts to compare and look at services that are comparable in terms of staff resources and produce a set of benchmarks that will further support the work in identifying staffing requirements.

MHSOP

3.13. Variances are seen in regard to the MHOST results for MHSOP which, similarly to SIS, requires deeper understanding.

3.14. Research undertaken in preparation for the zonal engagement model of care highlighted a variation in service provision and staffing requirements. There remains a requirement to achieve additional understanding with regard to the respective clinical models of care and ways of working across the localities, including service provision within the local community and TEWV community services, and the impact to ward staffing needs.

Community Teams

3.15. The 2019/20 establishment review showed that 8% of the 196 community teams had RAG rated themselves as Red or Red-Amber based on criteria (appendix 2), where services had also identified their mitigating actions to support these teams. Planned work, delayed due to COVID, includes consideration towards the use of evidence based tools within the community setting, community safe staffing dashboards, community based electronic rosters with the potential rollout of Safecare pending a successful deployment of evidence based tools.

3.16. As part of the NHS long term plan (2019) local areas were being asked to realign community mental health services with primary care networks, creating 'new and integrated models of primary and community mental health care' by 2023/24. (NHSE, 2019). The Community Mental Health Framework (CMHF) complements the Trust's vision, and is a focus for further planning and delivery, building on established partnership working (including long-standing integrated teams for adults). A model that is flexible, accessible and proactive is being developed, whilst the ambition is it to apply to all current and potential service users, there is a priority towards transformation for those with moderate to severe mental illness across our adult population, in line with the CMHF.

3.17. Detailed plans are anticipated to be developed in the next 6-9 months to fully transform mental health care across primary, community and secondary care settings over the coming 3.5 years to create provision based on need, not diagnosis, operating in a trauma informed way. This includes systemic approaches to address the social determinants of mental ill health and health inequalities through existing public health strategies. The local models should provide wrap around support to individuals/their families with services aligned at PCN level that will bring community, voluntary and statutory services together in a way that removes barriers and optimises data and information sharing.

Invest to improve initiatives

3.18. Analysis of Trust incidents, patient activity, staff and service user feedback and recent CQC inspection activity all indicate that there a number of challenges currently facing the Trust in relation to the delivery of high quality, safe inpatient care. This is also demonstrated by a high and increasing number of shifts required for the reason of 'enhanced observation', management of ligature risks, substance misuse incidents,

observation of service users at night, physical health monitoring post rapid tranquilisation and patient falls data.

3.19. Whilst the focus is on staffing establishments, "invest to improve" initiatives will ensure safer and more effective care can be provided and may also deliver significant productivity and financial savings by freeing up time to care.

3.20. The initiatives below that are currently being piloted and/or implemented in parts of the Trust should be considered 'in the round' alongside staffing establishments especially given current recruitment and retention issues:

- **Zonal engagement model of care**. Westerdale South, Tees MHSOP Organic ward is currently piloting this model. Whilst Covid-19 has impacted the pilot, it is shown to be having a positive effect, evidencing a reduction in the number of falls and physical interventions related to violence and aggression.
- **Oxehealth Digital Care Assistant**. The business case agreed by SLG 17th February 2021 to extend into areas with high self-harm incident data. The expectation is not for the DCA to replace staff in ensuring patient safety as it is designed to assist staff in this area, however part of the evaluation will also consider any impacts to temporary staffing usage on the wards involved, particularly in relation to observation and night.
- **Ward Clerk Review**. The Clinical Team Administrator (CTA), also referred to as ward clerks, provides an important supportive role within clinical teams in delivering patient care. Establishment reviews have identified a continued theme that clinical staff, in particular nursing staff, spend an increasing amount of time on non-clinical duties which could be better utilised in delivering therapies and clinical interventions to patients. Maximising clinical time for MDT members will also enable them to spend more value added time with the client group, thus improving clinical outcomes and patient satisfaction.

3.21. The NHSi Model Hospital provides a national benchmark of CHPPD for peer Trusts, which is used here to identify the gap in our budgeted establishment to that of these benchmark values.

3.22. The AMH A&T CHPPD value of 7.7 and PICU's 20.1 is reflective of the pre-covid average of the actual rostered ward staffing. The peer Trust median CHPPD value for this same period is 9.16 and 19.52 for AMH A&T and PICUs respectively.

- Appendix 3 (first table) shows what the current funded position equates to in terms of total hours per day and Care Hours Per Patient Day (CHPPD) and gives an average of 5.34 CHPPD for AMH A&T wards and 12 CHPPD for PICUs.
- The second table in appendix 3 shows the total hours and CHPPD based on the pre-covid Trust average for the rostered CHPPD, which includes a small number AHPs. This would cost £16.8m based on the benchmark national skill mix and the current bed numbers in the Trust.
- The final table shown in appendix 3 identifies the Gap between the pre-covid Trust average and the current funded CHPPD. This shows a total gap of 646 hours per day for the Trust and a gap of 28.28 CHPPD for AMH A&T wards and 14 CHPPD for PICUs,

and an average CHPPD gap of 3.02 per ward. The cost to bridge this gap would be a total of £5.5m to deliver at the pre-covid Trust average level CHPPD and skill mix, which equates to an estimated additional 78.66 registered WTEs and 75.37 HCSW WTEs totalling 154 WTEs. It is noted that if we were to consider the Trust average CHPPD without including the AHP staffing at this point, this would reduce to £4.97m.

3.23. It is recommended that work is completed to bridge this gap in two phases:

i) **Immediate AMH & PICU ward priority**, to add an additional Band 6 7-day daytime shift in for all wards, and to skills mix one band 3 12 hour shift across 7 days to band 5 for all wards and by recruiting substantively to these WTE requirements rather than utilising flexible staffing.

ii) **By the end of May 2021 AMH & PICU** - Although it can be seen that the Trust is already staffing to a higher level of CHPPD more work is needed to understand the CHPPD from proposed additional roles, including for activities and to understand how the additional hours translate into a workable roster for the different ward sizes (to retain the relativity of CHPPD). This will be included in the second phase of work within the next month and will need to consider resourcing and commissioner engagement.

Staffing Establishments - Priorities and Plan			
Where	**What**	**By When**	**Who**
AMH & PICU - Phase 1	• Address immediate priorities with regard to core group staff numbers and skill mix (RP to HCSW ratios), i.e. those that are currently rostered to the wards/units. Increase immediate priorities for Band 6 and band 5 ward staffing	Feb-21	Finance / Ops / Workforce
	• Utilise CHPPD and MHOST benchmark data to identify shortfalls on budgeted staffing establishments.		Finance / Right Staffing
	• Additional staffing resources in addition to the core staff group to be recruited in post for ward support:- site based Practice Development Leads and Peer Support Workers; ward based 7/7 admin and 7/7 activity coordinators.		Finance / Ops / Workforce
	• Utilise CHPPD and MHOST benchmark data and identified shortfalls on budgeted staffing establishments to proposed workable rosters by ward (retaining relativity of CHPPD). Agree route to navigate through Commissioners and including visbiility via Quality Board	Mar-21	
SIS	• Identify immediate priorities with regard to staff numbers and skill mix.	Mar-21	SIS / Ops
	• As part of the collaborative working with CNTW, commence benchmarking exercises regarding staffing resources and requirements.		SIS / Ops / Workforce / Finance / Right Staffing
	• Develop a prioritised plan of action based upon these findings, including timescales to complete discussions with Commissioners and via Quality Board		SIS / Ops / Workforce / Finance / Right Staffing
MHSOP	• Gain a deeper level of understanding of the factors impacting upon staffing requirements within each of the localities, such as clinical models of care, local service provision, and community resources.	Apr-21	MHSOP / Ops / Clinical
	• Review evaluation of zonal engagement model and consider potential roll out to other wards.		MHSOP / Ops / Finance
	• Develop a prioritised plan of action based upon these findings.		MHSOP / Ops / Finance / Workforce / Right Staffing
AMH & PICU - Phase 2	• Extend the work of AMH & PICU phase 1 in more detail to consider staffing within the centralised resources, which are not currently rostered – this will appear to apply more so to the Psychology and AHP staff groups in particular.	May-21	Therapies / Ops / Finance / Workforce / Right Staffing
	• Initiate contact and work collaboratively with local peer Trusts regarding CHPPD to develop a more granular view and benchmark.		Ops / Finance / Workforce / Right Staffing
	• Review the impacts these findings have upon the staffing numbers and skill mix		Therapies / Ops / Finance / Workforce / Right Staffing
	• Develop a plan regarding how these findings and impacts can be actioned in the work place, for example consideration towards flexible shift patterns, de-centralising of resources.		Therapies / Ops / Finance / Workforce / Right Staffing
LD and Adult Rehab	• Identify immediate priorities with regard to staff numbers and skill mix.	May-21	Therapies / Ops / Finance / Workforce / Right Staffing

Figure 2: High Level plan of prioritised actions also presented in appendix 4

3.24. Further detailed analysis is required to determine the impact of centralised staffing resources upon the rostered staffing levels in delivering CHPPD. It is anticipated that this will further improve the Trust's CHPPD value towards meeting the peer Trust median values for the AMH service, and this will therefore require review and further consideration once this analysis has been completed.

3.25. Appendix 5 shows the cost of moving the current funded WTEs from the current skill mix to the benchmarked National skill mix specified in the MHOST. This would cost £78k on budgeted numbers but significantly more on what is currently being worked. If the CHPPD gap was calculated at the Trusts current funded skill mix the gap would only reduce by £21k to £5.48m.

3.26. Figure 3 provides a summary of costings for the recommendations for immediate investment in AMH as described, which is further detailed in appendix 6.

Additional Resource for Immediate response	D&D		Tees		NYY		Total	
	wte	£	wte	£	wte	£	wte	£
OTA's	3.22	113,200	8.94	271,846	7.15	217,477	19.31	602,523
Ward Clerks	4.79	179,007	3.39	145,260	3.15	123,091	11.33	447,358
Practice Development Support	4.00	234,513	4.00	234,513	4.00	234,513	12.00	703,540
Peer Support	4.00	121,645	4.00	121,645	4.00	121,645	12.00	364,935
Additional Band 6 Day shift	8.94	423,199	8.94	423,199	7.15	338,559	25.03	1,184,957
Skill Mix B3 shift to B5 shift	0.00	111,880	0.00	111,880	0.00	89,504	0.00	313,263
Total	**24.95**	**1,183,444**	**29.27**	**1,308,343**	**25.45**	**1,124,789**	**79.67**	**3,616,576**

Figure 3: Summary of recommended expenditure for AMH immediate response

Secure Inpatient Services

3.27. The Secure Inpatient Service has met to assess options for the service, building on the principles which were agreed to address AMH staffing requirements. The service principles have been broadly replicated from AMH but with additional consideration of specific forensic service requirements.

- There should be a core staffing offer.
- All qualified practitioners should be supporting ward delivery over a 7 day period (this includes Nursing and Therapies professions)
- Acknowledgement of the current sickness rate/ maternity impact on day to day staffing numbers – to be reflected in staffing models
- Seven day administrative staffing should be provided – targeting duty nurse coordinator capacity and pathways
- Consideration of activities / “pinch points” in the day / over 7 days a week with a focus on reducing incidents and enabling access for some complex groups who may not be able to fully access current therapy / activity arrangements
- Assessment of best practice and service models to facilitate the most effective leave arrangements and ensure the security of the service

3.28. The service has identified a number of additional areas for consideration but the first phase of safety service investment for immediate additional support for £1.86M is outlined below in figure 4, and is further detailed in appendix 7. Figure 4 also highlights the associated benefits of the staffing measures suggested.

3.29. Further work is to be undertaken to explore the impacts of the staffing uplift (headroom) required for the SIS wards and the availability of staff who may be subject to restrictive duties / extended periods of leave.

Table 2 - Summary of Additional Support	wte	£	Releasing time to care	Enhanced quality and skill mix	Enhanced patient experience and reduced incidents	Support workforce development and retention	Reduced bank and overtime	Reduced existing overspend	Leadership and Culture
Immediate Additional Support									
Admin Support	6.00	£159,398	√	√	√	√		√	
Security Team	1.00	£44,052	√	√	√	√	√	√	√
Practice Development	4.50	£263,828		√	√	√			√
Activity Coordinators	20.00	£559,044	√	√	√	√	√	√	√
Rostered Nurse Skill Mix B3 to B5	Skill Mix	£80,336	√	√	√	√	√	√	√
Rostered Nurse Skill Mix B5 to B6	Skill Mix	£95,108	√	√	√	√	√	√	√
Leave Team	5.80	£176,414	√	√	√		√	√	√
Staffing Coordinator	1.00	£51,203	√	√	√	√	√	√	√
Recovery Team	1.00	£29,531	√	√	√	√	√	√	√
Skill Mix of reception team	Skill Mix	£41,967	√	√	√	√	√	√	√
Peer Support	11.74	£359,606	√	√	√	√	√	√	√
TOTAL	**51.04**	**£1,860,488**							
Future Opportunities									
Site Seclusion Support	8.58	£302,851	√	√	√	√	√	√	√
SALT support to 7 day	1.92	£81,825		√	√	√			√
Recovery Team	3.00	£88,592	√	√	√	√	√	√	√
Rostered Nurse Skill Mix B3 to B4	Skill Mix	£88,018	√	√	√	√	√	√	√
Modern Matron - Langley/Oakwood	0.50	£33,501	√	√	√	√	√	√	√
Psychology Ward support	4.99	289,845	√	√	√	√	√	√	√
Staffing Lead	1.00	£67,002	√	√	√	√	√	√	√
Staff well being support	1.00	£29,684	√	√	√	√	√	√	√
TOTAL	**20.99**	**£981,318**							
OVERALL TOTAL	**72.03**	**£2,841,806**							

Figure 4: Summary of recommended expenditure for Secure Inpatient Service immediate response

4. IMPLICATIONS:

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

Adhering to NHSI requirements will provide compliance with CQC standards. Insufficient staffing and skill mix can negatively impact on the safe domain ratings during CQC inspection, Addressing the inpatient staffing skill mix ratios will additionally enhance compliance with the CQC well led framework.

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

Investment in substantive staffing levels will reduce dependency upon temporary staffing usage and provide increased quality of care and safety to patients, together with a greater management of resources will also impact on agency use and on staff morale and sickness therefore reducing costs.

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

None identified.

4.4. **Equality and Diversity**:

None identified.

5. **RISKS:**

- Insufficient numbers of substantive staffing will have a detrimental impact upon patient safety, patient care and treatment, staff wellbeing, morale and staff retention.
- Continued use and reliance upon temporary staffing and overtime will have a negative impact upon the quality, and continuity of care for the patient, staff experience, the Trust financial position, and longer term the safety of patients upon the wards.
- Not having a proactive and timely recruitment process between services and human resources to ensure that budgeted staffing establishments are consistently achieved will increase the requirement and need for flexible staffing, and as such impact upon patient care and staff wellbeing.
- Inability to mitigate the wards that are below the benchmark values for RP to SW ratios could have a negative impact on the effective clinical leadership and the culture of the Trust and ultimately the potential to impact upon of the safety and quality of patient care.
- National shortages of registered nurses and that of the local picture impact on recruitment, and so there may be long lead times to recruit to the required registered practitioner posts identified.
- The revised investment plan may not reduce the current overspend in staffing
- The future case for change will need to be articulated as part of our discussions with commissioners; and with respect to Secure Inpatient Services, the Provider Commissioner model.

6. **CONCLUSIONS:**

6.1. A leadership group, consisting of: Elizabeth Moody, Director of Nursing & Governance; Liz Romaniak, Director of Finance & Information; Hannah Crawford, Acting Lead for AHP & Social Work; and Ruth Hill, Chief Operating Officer, met to progress staffing establishment work in response to the recent CQC action plan. In addition, requests were made at ward and specialty level to understand some of the service issues. From this a set of service principles were developed with an emphasis on improving safety:

- There should be a core staffing offer on every AMH and SIS ward – this should cover Nursing/ AHPs & SWs / Psychology/ Administration.
- We should aim to meet, as a minimum, the MHOST ratio of 54%:46% - Registered Practitioner: Support Worker (i.e. Non Registered Practitioner) for Adult Admissions wards; the ratio for MSU and LSU and 50%:50% and 53%:47% respectively.
- All qualified practitioners should be supporting ward delivery over a 7 day period (this includes Nursing and Therapies professions).
- Seven day administrative staffing should be provided for AMH wards (undertaking a core function of ward based tasks including focusing on supporting safety reporting/ ward related reporting).
- Consideration of activities / “pinch points” in the day / over 7 days a week

- Ward Managers are not in the ward staffing numbers. However, we need to be careful when using for comparisons as nationally (e.g. CHPPD) and MHOST include the Ward Managers as part of the "ward staffing establishment".

6.2. This work has informed the recommendations set out below for immediate investment in AMH admission wards and Secure Inpatient Service wards. It is recognised that further work still needs to be undertaken with regard to CHPPD and multi-professional ward rosters.

6.3. A summary of the investment required to meet the requirements of the immediate additional support is provided in figure 5.

Immediate Additional Support		
Area	**WTE**	**Cost (£)**
AMH & PICU	79.67	3,616,576
Forensic	51.04	1,860,488
Total	**130.71**	**5,477,064**

Figure 5: Summary of investment expenditure for immediate additional support

6.4. The overall expectation is to positively impact upon the following areas of:

- Time to care – releasing nursing staff time to care
- Leadership and culture
- Enhance quality focus and skill mix
- Enhance patient experience and reduce incidents
- Support workforce development and retention
- Reduce the use of bank staff and reliance on overtime
- Reduce existing staffing overspend

6.5. To support the monitoring of the progress towards meeting these expectations, a subgroup has now been established to define a set of metrics and coordinate the data collection requirements to provide this oversight.

6.6. In reference to the particular point of reducing existing staffing overspend, Figure 6 shows the current overspending for each area for the AMH and SIS wards, which provides includes the impact of Covid and is further detailed in appendix 8. It is anticipated that whilst the expectation is that the proposed investment for immediate support will not necessarily eliminate this overspend variance, but that it will however reduce it. This will be a factor of the metrics to be monitored.

Variance	20/21 exc Covid cost	20/21 inc Covid cost		Cost of Covid shifts
ADULT & PICU	**£**	**£**		**£**
Tees	689,218	1,675,186		985,968
Durham & Darlington	986,172	2,182,330		1,196,158
North Yorkshire & York	667,090	1,262,776		595,686
Total Adult & PICU	**2,342,480**	**5,120,292**		**2,777,812**
SIS	**£**	**£**		**£**
FMH	1,250,941	1,555,620		304,679
FLD	646,933	848,184		201,251
Total SIS	**1,897,874**	**2,403,804**		**505,930**

Figure 6: Summary of investment expenditure for immediate additional support

6.7. The current plan, as detailed in appendix 4, identifies for this work to continue into other areas of speciality which will include MHSOP, Adult Rehab and LD before commencing the scheduled phase 2 approaches, in addition to considerations towards the community teams.

7. RECOMMENDATIONS:

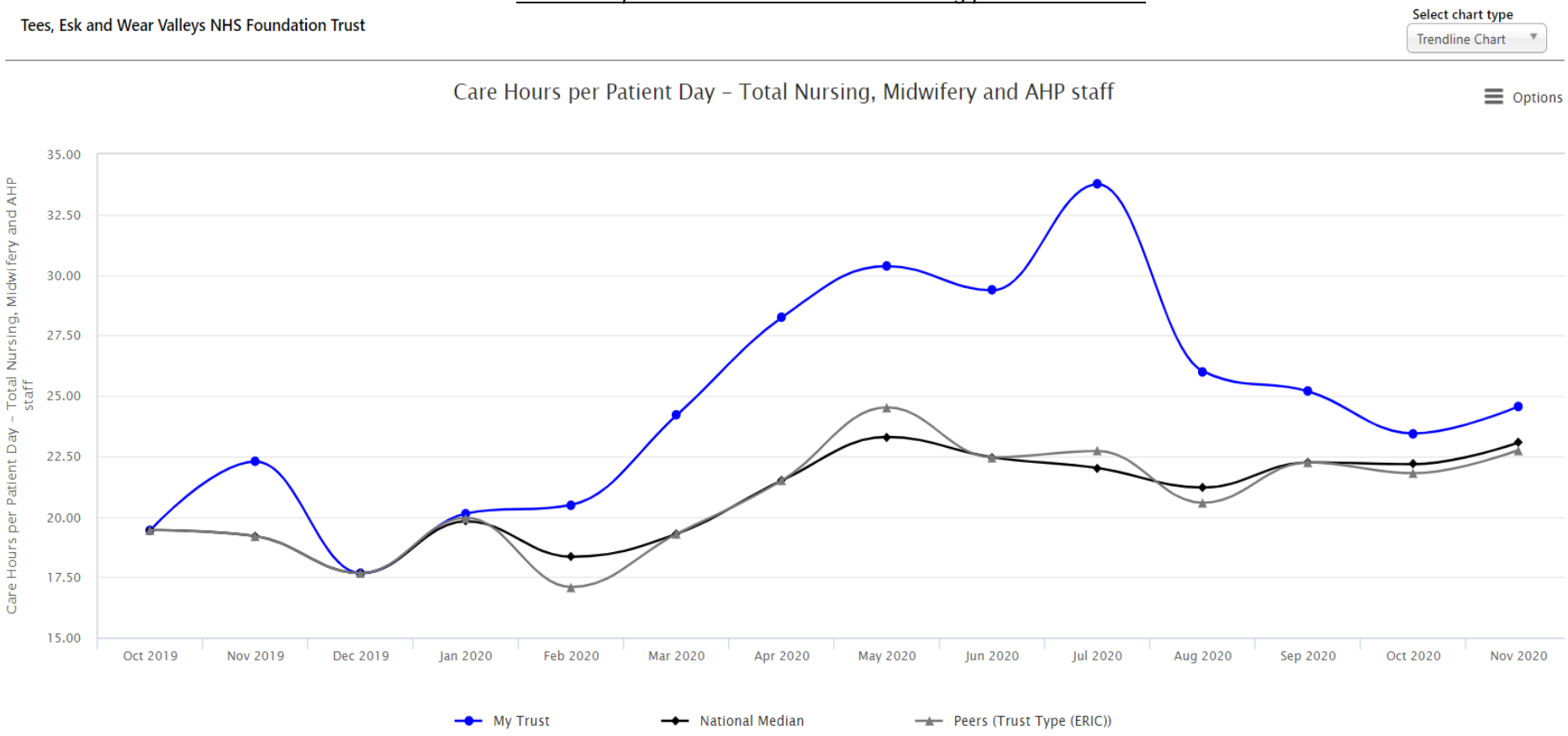
7.1. That the Trust Board note the content of the report and consider what action is needed and:

- To provide additional funding as highlighted shown in figure 5 to meet the immediate staffing priorities for the AMH admission / PICU wards and Secure Inpatient Services as outlined in the paper.
- To approve the plan and timescales for further consideration of staffing establishments in the remaining inpatient ward areas.

Elizabeth Moody: **Executive Director of Nursing and Governance**
Joe Bergin: **Right Staffing Senior Programme Manager**

Appendix 1

Model Hospital - PICU CHPPD data including pre-covid months



Appendix 2

RED	RED / AMBER	AMBER	AMBER / GREEN	GREEN
Not Safe Major adjustment required Not Safe and poor quality	**Partially Safe** Significant adjustment required Partially Safe and concerns about quality	**Safe** Although moderate adjustments required Safe and Satisfactory quality	**Safe** Although minor adjustments required Safe and good quality	**Safe** No changes required Safe and High quality

RAG rating criteria for 2019/20 establishment review

IP / CMHT	Loc	Spec	Team	RAG Oct 2019	Actions and mitigations - Feb 2020
InPt	D&D	AMH	Elm Ward	**Red**	Action plan in place. There has been a reduction in incidents linked to discharge of one patient however concerns remain around how they manage EUPD presentations – there is work aligned to the action plan to look at the model and intervention provided to this client group.
CMHT	D&D	AMH	Easington Access	**Red**	RPIW and Single Point Of Access model to address issues – this will be operational by March 2020.
CMHT	D&D	AMH	Tertiary Pyschosis	**Red**	20/21 service plan addressing requirements. An identified piece of work aligned to the business plan to review the function/need of the team current thinking is that the resource needs to be embedded in the teams.
CMHT	NYY	AMH	Scarborough Community	**Red**	Have been without Psychology post for close to a year, post now recruited to, commenced Feb 2020. NYCC funding removed for dual diagnosis, however locality actions from the Trust have been able to maintain level of funding into team for the short term; post remains at risk. Still require additional means to secure a B6 nurse. NYCC have secured funding for B7 homeless worker to support for 12month secondment – just about to going into recruitment process.
CMHT	NYY	AMH	Ham & Rich EIP	**Red**	Commitment of £300k funding from CCG for next financial year, however still a shortfall of ~£600k of required amount. Mental Health Investment funding paper has returned to CCG this week to identify where spending is being directed. As a result the service is to be measured against Level 2 of the National Quality Standards as opposed to the current Level 3 requirements. Service remains vulnerable, locally trying to increase support worker capacity.
CMHT	NYY	AMH	SWR EIP	**Red**	
CMHT	NYY	AMH	NY Eating Disorder	**Red**	Needs decision how Eating Decisions will be funded going forward. This is documented as part of the Mental Health Investment funding paper – discussions with commissioners, however no decision regarding a funding or how this will be addressed – requires further discussions at the earliest opportunity
CMHT	NYY	AMH	York Eating Disorders	**Red**	
CMHT	NYY	CYPS	York Community	**Red**	The Trust has agreed to implement an intensive support plan into these CAMHS services following an external review by

CMHT	NYY	CYPS	Scarborough ADHD	**Red**	Meridian, a Productivity Company. The findings from the Meridian report illustrated the need for dedicated KPO, Management and Leadership support to work within a project management framework to address the capacity and demand issues and ensure all resources are utilised to maximum benefit for patient care.
CMHT	NYY	CYPS	York & Selby Community	**Red**	
CMHT	NYY	CYPS	Scarborough CAMHS	**Amber Red**	
CMHT	D&D	CYPS	South Durham Tier 3	**Amber Red**	Tier 2 & Tier 3 teams are functioning as one team/new model of working. Current and persistent escalated issues with PARIS data in aligning the teams continue to remain; this prevents the ability to use data to inform and support the effective and optimal delivery of care. Recruitment remains an issue, high level of internal churn from summer 2019 which is impacting upon sickness levels; high numbers on caseloads, waiting referrals and hidden "waiters. Ongoing mitigating actions include recruitment drives, QIS event June 2020, further escalation of data issues.
CMHT	D&D	CYPS	South Durham Tier 2	**Amber Red**	
InPt	Tees	AMH	Kirkdale	**Amber Red**	Issues now resolved with ward closure. Previous issues related to staff transitions.
InPt	Tees	AMH	Lustrum Vale	**Amber Red**	Issues now improved due to transitioning staff from Kirkdale into ward team, no immediate or significant concerns.
CMHT	Tees	AMH	Middlesbrough Access	**Amber Red**	Increased staffing resource into team alleviating pressures. Indications are that the situation has improved. Identified planned ongoing actions to mitigate risks remain on track.
CMHT	Tees	AMH	Middlesbrough Affective	**Amber Red**	Easing of pressure on Middlesbrough Access team resulting in a positive impact on the pressures experienced in the Affective team as the two teams work closely together. Indications are that the situation has improved. Identified planned ongoing actions to mitigate risks remain on track.
InPt	Tees	MHS OP	Westerdale South	**Amber Red**	Zonal Engagement pilot underway; feedback positive, reduction in falls noted. Full recruitment to required posts expected end of March 2020. Expectations to reflect as green RAG rating once achieved – this is mitigating previous highlighted concerns.
CMHT	Tees	MHS OP	North Tees Liaison Psychiatry	**Amber Red**	Introducing health roster – recent review of shift patterns has enabled increased and better use of current resources; this new roster model to be in place 01/04/20. Bid placed to secure additional funding to increase staffing levels; decision expected Feb/March 2020.
CMHT	Tees	MHS OP	South Tees Liaison Psychiatry	**Amber Red**	Introducing health roster – recent review of shift patterns has enabled increased and better use of current resources; this new roster model to be in place 01/04/20. Bid placed to secure additional funding to increase staffing levels; decision expected Feb/March 2020.
CMHT	Tees	MHS OP	Tees Intensive Community Liaison	**Amber Red**	Initial concerns re staffing levels and caseload size - referral rates and caseloads have reduced dramatically in recent months since establishment review. Hold placed on increasing staffing as current staffing levels now sufficient with new reduced caseload & referral rates - to be monitored across the coming months for changes. All current risks are mitigated by internal plans; longer term plans include ongoing work with RCRP review of overall care support and provision

CMHT	NYY	LD	York Medics	**Amber Red**	Issues and risks reported to still remain with recruiting to substantive consultant post. Recent anticipated appointment of consultant failed, applicant declined 2 days before agreed take up of post. Locum currently providing cover who has stated commitment until the end of year, however risk remains with the potential of short notice nature of locum posts. Post currently out to advert again; also recruiting to a B4 Associate Practitioner post to support with clinic A&C work and follow ups; additionally NMP providing support into the teams where required, local actions mitigating risks at this current time.
InPt	NYY	MHS OP	Rowan Lea	**Amber Red**	Difficulties in recruiting to vacant posts, impacted by difficulties within recruitment process. Reliance upon temporary staffing increasing demand upon substantive staff. Head of Nursing and recruitment team taking lead in support; recruitment fairs being organised. Improving roster efficiencies work underway to maximise utilisation of current resources. Seeking to recruit above budgeted establishment to maintain required establishment for full bed occupancy.
CMHT	NYY	CYPS	Eating Disorders	**Amber Red**	Awaiting the release of the agreed funding from the New Models of Care programme. It is anticipated this will be made available from April 2020. Once recruited to, the service rating will be reviewed.
CMHT	H&J	H&J	HMP Durham	**Amber Red**	High demands from referrals and high prison transfer rates placing extra strain on staffing resources resulting in increased staff turnover and sickness due to work related stress. The current situation is reported to be slowly deteriorating. New approach to triage and ways of working developed, but unable to deploy until sufficient staffing numbers are in post. Issues continue with recruitment and retention; forensic wide task and finish group set up to focus and address recruitment issues, to include working closely with recruitment team. Issues with progressing staff through recruitment highlighted. Issues escalated, within Trust and National H&J; additional funding for staffing resource allocated; just appointed experienced advanced practitioner, exploring development of evidence based tool to asses demand and capacity.

Teams with RAG ratings of Red or Amber/Red for 2019/20 establishment review

Appendix 3

Summary of Care Hours Per Patient per Day and Financial Cost

Locality			DURHAM AND DARLINGTON					TEESSIDE					NORTH YORKSHIRE & YORK					Total / Average A&T	Total / Average PICU	Trust Total
Service			A&T				PICU	A&T				PICU	A&T							
Ward			Tunstall	Farnham	Elm	Maple	Cedar	Bilsdale	Overdale	Stockdale	Bransdale	Bedale	Danby	Esk	Ebor	Minster				
Beds			20	20	20	20	10	14	18	18	14	10	13	13	18	18		206	20	226
Rostered shift pattern			5,3	5,3	5,3	5,3	6,4	4,3	4,3	4,3	4,3	6,4	4,3	4,3	5,3	5,3				
Total shifts			8	8	8	8	10	7	7	7	7	10	7	7	8	8				
Rostered Staff			wte	wte	wte	wte	wte	wte	wte	wte	wte	wte	wte	wte	wte	wte		wte	wte	wte
Registered Nursing			12.67	12.67	12.67	12.67	15.53	9.79	9.79	9.79	9.79	15.28	10.35	10.35	12.27	12.27		135.09	30.81	165.90
Support			11.44	11.44	11.44	11.44	14.30	10.97	10.97	10.97	10.97	13.71	10.73	10.73	10.97	10.97		133.04	28.01	161.05
Total			24.11	24.11	24.11	24.11	29.83	20.76	20.76	20.76	20.76	28.99	21.08	21.08	23.24	23.24		268.13	58.82	326.95
Rostered Staff Skill Mix %																				
Registered Nursing			52.55%	52.55%	52.55%	52.55%	52.06%	47.16%	47.16%	47.16%	47.16%	52.71%	49.10%	49.10%	52.80%	52.80%		50.38%	52.38%	50.74%
Support			47.45%	47.45%	47.45%	47.45%	47.94%	52.84%	52.84%	52.84%	52.84%	47.29%	50.90%	50.90%	47.20%	47.20%		49.62%	47.62%	49.26%
Funded Total hours per day		Total shifts x 12 hrs	96	96	96	96	120	84	84	84	84	120	84	84	96	96		1080	240	1320
Registered Nursing			50	50	50	50	62	40	40	40	40	63	41	41	51	51		544	126	670
Support			46	46	46	46	58	44	44	44	44	57	43	43	45	45		536	114	650
Funded CHPPD		Total hrs per day/Beds	4.80	4.80	4.80	4.80	12.00	6.00	4.67	4.67	6.00	12.00	6.46	6.46	5.33	5.33		64.12	24.00	5472.00
Registered Nursing			2.52	2.52	2.52	2.52	6.25	2.83	2.20	2.20	2.83	6.33	3.17	3.17	2.82	2.82		32.13	12.57	44.70
Support			2.28	2.28	2.28	2.28	5.75	3.17	2.47	2.47	3.17	5.67	3.29	3.29	2.52	2.52		32.00	11.43	43.42
Trust Pre-Covid Average CHPPD		Avg CHPPD x 12hrs	154	154	154	154	190	108	139	139	108	190	100	100	139	139		1586	380	1966
Registered Nursing			83	83	83	83	102	58	74	74	58	102	54	54	74	74		850	204	1054
Support			71	71	71	71	88	50	64	64	50	88	46	46	64	64		736	176	912
	PICU	A&T																		
Trust Pre-Covid Avg CHPPD	19.0	7.7	7.70	7.70	7.70	7.70	19.00	7.70	7.70	7.70	7.70	19.00	7.70	7.70	7.70	7.70		92.40	38.00	-
Registered Nursing	48%	53.60%	4.13	4.13	4.13	4.13	9.12	4.13	4.13	4.13	4.13	9.12	4.13	4.13	4.13	4.13		49.53	18.24	-
Support	52%	46.40%	3.57	3.57	3.57	3.57	9.88	3.57	3.57	3.57	3.57	9.88	3.57	3.57	3.57	3.57		42.87	19.76	-
Cost of Pre-Covid Avg. CHPPD			£ 1,315,107	£ 1,315,107	£ 1,315,107	£ 1,315,107	£ 1,622,535	£ 920,575	£ 1,183,597	£ 1,183,597	£ 920,575	£ 1,622,535	£ 854,820	£ 854,820	£ 1,183,597	£ 1,183,597		£ 13,545,605	£ 3,245,070	£ 16,790,675
GAP - Total hours per day			58	58	58	58	70	24	55	55	24	70	16	16	43	43		506	140	646
Registered Nursing			31	31	31	31	34	13	29	29	13	34	9	9	23	23		271	67	339
Support			27	27	27	27	36	11	25	25	11	36	7	7	20	20		235	73	308
GAP - CHPPD			2.90	2.90	2.90	2.90	7.00	1.70	3.03	3.03	1.70	7.00	1.24	1.24	2.37	2.37		28.28	14.00	14.88
Registered Nursing			1.60	1.60	1.60	1.60	2.87	1.30	1.93	1.93	1.30	2.79	0.95	0.95	1.31	1.31		17.40	5.67	23.07
Support			1.30	1.30	1.30	1.30	4.13	0.40	1.11	1.11	0.40	4.21	0.28	0.28	1.06	1.06		10.88	8.33	19.21
Cost of GAP			£ 495,300	£ 495,300	£ 495,300	£ 495,300	£ 588,339	£ 203,244	£ 466,265	£ 466,265	£ 203,244	£ 588,339	£ 137,488	£ 137,488	£ 363,789	£ 363,789		£ 4,322,775	£ 1,176,677	£ 5,499,452
wte GAP Registered Nursing			7.27	7.27	7.27	7.27	8.69	2.68	6.14	6.14	2.68	8.80	1.88	1.88	5.36	5.36		61.18	17.48	78.66
wte GAP Support			6.56	6.56	6.56	6.56	8.00	3.00	6.88	6.88	3.00	7.89	1.95	1.95	4.79	4.79		59.48	15.89	75.37
wte GAP Total			13.83	13.83	13.83	13.83	16.69	5.67	13.02	13.02	5.67	16.69	3.84	3.84	10.15	10.15		120.66	33.37	154.04
Cosf of GAP excluding headroom of 27.7%			£ 387,862	£ 387,862	£ 387,862	£ 387,862	£ 460,719	£ 159,157	£ 365,126	£ 365,126	£ 159,157	£ 460,719	£ 107,665	£ 107,665	£ 284,878	£ 284,878		£ 3,385,102	£ 921,439	£ 4,306,540
Cost of GAP on original skill mix			£ 493,835	£ 493,835	£ 493,835	£ 493,835	£ 595,184	£ 199,556	£ 457,804	£ 457,804	£ 199,556	£ 596,278	£ 135,744	£ 135,744	£ 362,966	£ 362,966		£ 4,287,479	£ 1,191,462	£ 5,478,940

CHPPD breakdown to meet pre-covid Trust average CHPPD levels for AMH and PICU

Appendix 4

Staffing Establishments - Priorities and Plan			
Where	**What**	**By When**	**Who**
AMH & PICU - Phase 1	• Address immediate priorities with regard to core group staff numbers and skill mix (RP to HCSW ratios), i.e. those that are currently rostered to the wards/units. Increase immediate priorities for Band 6 and band 5 ward staffing	Feb-21	Finance / Ops / Workforce
	• Utilise CHPPD and MHOST benchmark data to identify shortfalls on budgeted staffing establishments.		Finance / Right Staffing
	• Additional staffing resources in addition to the core staff group to be recruited in post for ward support:- site based Practice Development Leads and Peer Support Workers; ward based 7/7 admin and 7/7 activity coordinators.		Finance / Ops / Workforce
	• Utilise CHPPD and MHOST benchmark data and identified shortfalls on budgeted staffing establishments to proposed workable rosters by ward (retaining relativity of CHPPD). Agree route to navigate through Commissioners and including visbiility via Quality Board	Mar-21	
SIS	• Identify immediate priorities with regard to staff numbers and skill mix.	Mar-21	SIS / Ops
	• As part of the collaborative working with CNTW, commence benchmarking exercises regarding staffing resources and requirements.		SIS / Ops / Workforce / Finance / Right Staffing
	• Develop a prioritised plan of action based upon these findings, including timescales to complete discussions with Commissioners and via Quality Board		SIS / Ops / Workforce / Finance / Right Staffing
MHSOP	• Gain a deeper level of understanding of the factors impacting upon staffing requirements within each of the localities, such as clinical models of care, local service provision, and community resources.	Apr-21	MHSOP / Ops / Clinical
	• Review evaluation of zonal engagement model and consider potential roll out to other wards.		MHSOP / Ops / Finance
	• Develop a prioritised plan of action based upon these findings.		MHSOP / Ops / Finance / Workforce / Right Staffing
AMH & PICU - Phase 2	• Extend the work of AMH & PICU phase 1 in more detail to consider staffing within the centralised resources, which are not currently rostered – this will appear to apply more so to the Psychology and AHP staff groups in particular.	May-21	Therapies / Ops / Finance / Workforce / Right Staffing
	• Initiate contact and work collaboratively with local peer Trusts regarding CHPPD to develop a more granular view and benchmark.		Ops / Finance / Workforce / Right Staffing
	• Review the impacts these findings have upon the staffing numbers and skill mix		Therapies / Ops / Finance / Workforce / Right Staffing
	• Develop a plan regarding how these findings and impacts can be actioned in the work place, for example consideration towards flexible shift patterns, de-centralising of resources.		Therapies / Ops / Finance / Workforce / Right Staffing
LD and Adult Rehab	• Identify immediate priorities with regard to staff numbers and skill mix.	May-21	Therapies / Ops / Finance / Workforce / Right Staffing

High Level plan of prioritised actions

Appendix 5

Cost of Moving Current funded skill mix to National skill mix

Locality			DURHAM AND DARLINGTON					TEESSIDE					NORTH YORKSHIRE & YORK				TOTAL
Service			A&T				PICU	A&T				PICU	A&T				
Ward			Tunstall	Farnham	Elm	Maple	Cedar	Bilsdale	Overdale	Stockdale	Bransdale	Bedale	Danby	Esk	Ebor	Minster	
Rostered Staff																	
Registered Nursing			12.67	12.67	12.67	12.67	15.53	9.79	9.79	9.79	9.79	15.28	10.35	10.35	12.27	12.27	165.90
Support			11.44	11.44	11.44	11.44	14.30	10.97	10.97	10.97	10.97	13.71	10.73	10.73	10.97	10.97	161.05
Total			**24.11**	**24.11**	**24.11**	**24.11**	**29.83**	**20.76**	**20.76**	**20.76**	**20.76**	**28.99**	**21.08**	**21.08**	**23.24**	**23.24**	**326.95**
Rostered Staff Skill Mix %																	
Registered Nursing			52.55%	52.55%	52.55%	52.55%	52.06%	47.16%	47.16%	47.16%	47.16%	52.71%	49.10%	49.10%	52.80%	52.80%	50.74%
Support			47.45%	47.45%	47.45%	47.45%	47.94%	52.84%	52.84%	52.84%	52.84%	47.29%	50.90%	50.90%	47.20%	47.20%	49.26%
National Skill Mix %	PICU	A&T															
Registered Nursing	48%	53.60%	12.92	12.92	12.92	12.92	14.32	11.13	11.13	11.13	11.13	13.92	11.30	11.30	12.46	12.46	175.25
Support	52%	46.40%	11.19	11.19	11.19	11.19	15.51	9.63	9.63	9.63	9.63	15.08	9.78	9.78	10.78	10.78	151.70
Total			**24.11**	**24.11**	**24.11**	**24.11**	**29.83**	**20.76**	**20.76**	**20.76**	**20.76**	**28.99**	**21.08**	**21.08**	**23.24**	**23.24**	**326.95**
Skill Mix change																	
Registered Nursing			0.25	0.25	0.25	0.25	-1.21	1.34	1.34	1.34	1.34	-1.37	0.95	0.95	0.19	0.19	6.05
Support			-0.25	-0.25	-0.25	-0.25	1.21	-1.34	-1.34	-1.34	-1.34	1.37	-0.95	-0.95	-0.19	-0.19	-6.05
			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**
Cost of Skill Mix change																	
Registered Nursing		**Band 6**	£ 3,823	£ 3,823	£ 3,823	£ 3,823	-£ 18,312	£ 20,199	£ 20,199	£ 20,199	£ 20,199	-£ 20,644	£ 14,342	£ 14,342	£ 2,821	£ 2,821	£ 91,459
		Band 5	£ 9,263	£ 9,263	£ 9,263	£ 9,263	-£ 44,367	£ 48,938	£ 48,938	£ 48,938	£ 48,938	-£ 50,015	£ 34,746	£ 34,746	£ 6,834	£ 6,834	£ 221,584
Support		**Band 3**	-£ 9,824	-£ 9,824	-£ 9,824	-£ 9,824	£ 47,053	-£ 51,901	-£ 51,901	-£ 51,901	-£ 51,901	£ 53,043	-£ 36,850	-£ 36,850	-£ 7,248	-£ 7,248	-£ 234,999
			£ 3,263	**£ 3,263**	**£ 3,263**	**£ 3,263**	**-£ 15,627**	**£ 17,237**	**£ 17,237**	**£ 17,237**	**£ 17,237**	**-£ 17,616**	**£ 12,238**	**£ 12,238**	**£ 2,407**	**£ 2,407**	**£ 78,045**
COST per shift pa (inc headroom)																	
Band 6	**60,457**	**25%**															
Band 5	**48,825**	**75%**															
Band 3	**38,835**	**100%**															

Skill Mix breakdown to meet MHOST benchmark levels for AMH and PICU

Appendix 6

Summary of Additional Staffing		OTA's		B3 A & C Ward clerks		B7 Practice Development		B3 Peer Support		Additional Band 6 shift per day		Skill Mix 1 Day shift B3 to B5		Total Additional	
		7 day - 7.5hrs		7 day - 7.5hrs		7 day - 7.5hrs		7 day - 7.5hrs		7 day - 7.5hrs		24/7			
Ward/Locality	**Beds**	**wte**	**£**	**wte**	**£**	**wte**	**£**	**wte**	**£**	**wte**	**£**	**wte**	**£**	**wte**	**£**
Tunstall	20	0.36	14,708	0.99	36,715	0.80	46,903	0.80	24,329	1.79	84,640	0.00	22,376	4.73	229,671
Farnham	20	0.36	14,708	0.94	35,634	0.80	46,903	0.80	24,329	1.79	84,640	0.00	22,376	4.68	228,590
Elm	20	0.36	14,707	0.79	31,790	0.80	46,903	0.80	24,329	1.79	84,640	0.00	22,376	4.53	224,745
Maple	20	0.36	14,707	1.29	43,080	0.80	46,903	0.80	24,329	1.79	84,640	0.00	22,376	5.03	236,035
Cedar (PICU)	10	1.79	54,369	0.79	31,787	0.80	46,903	0.80	24,329	1.79	84,640	0.00	22,376	5.96	264,404
TOTAL D&D	**90**	**3.22**	**113,200**	**4.79**	**179,007**	**4.00**	**234,513**	**4.00**	**121,645**	**8.94**	**423,199**	**0.00**	**111,880**	**24.95**	**1,183,444**
Bilsdale	14	1.79	54,369	0.56	26,175	0.80	46,903	0.80	24,329	1.79	84,640	0.00	22,376	5.73	258,792
Overdale	18	1.79	54,369	0.26	18,787	0.80	46,903	0.80	24,329	1.79	84,640	0.00	22,376	5.43	251,404
Stockdale	18	1.79	54,369	0.83	33,578	0.80	46,903	0.80	24,329	1.79	84,640	0.00	22,376	6.00	266,195
Bransdale	14	1.79	54,369	0.79	31,952	0.80	46,903	0.80	24,329	1.79	84,640	0.00	22,376	5.96	264,569
Bedale (PICU)	10	1.79	54,369	0.96	34,767	0.80	46,903	0.80	24,329	1.79	84,640	0.00	22,376	6.13	267,384
TOTAL TEES	**74**	**8.94**	**271,846**	**3.39**	**145,260**	**4.00**	**234,513**	**4.00**	**121,645**	**8.94**	**423,199**	**0.00**	**111,880**	**29.27**	**1,308,343**
Danby	13	1.79	54,369	1.29	42,276	1.00	58,628	1.00	30,411	1.79	84,640	0.00	22,376	6.86	292,701
Esk	13	1.79	54,369	0.29	17,784	1.00	58,628	1.00	30,411	1.79	84,640	0.00	22,376	5.86	268,209
Ebor	18	1.79	54,369	0.79	31,515	1.00	58,628	1.00	30,411	1.79	84,640	0.00	22,376	6.36	281,940
Minster	18	1.79	54,369	0.79	31,515	1.00	58,628	1.00	30,411	1.79	84,640	0.00	22,376	6.36	281,940
TOTAL NYY	**62**	**7.15**	**217,477**	**3.15**	**123,091**	**4.00**	**234,513**	**4.00**	**121,645**	**7.15**	**338,559**	**0.00**	**89,504**	**25.45**	**1,124,789**
TOTAL TRUST	**226**	**19.31**	**602,523**	**11.33**	**447,358**	**12.00**	**703,540**	**12.00**	**364,935**	**25.03**	**1,184,957**	**0.00**	**313,263**	**79.67**	**3,616,576**

Summary of additional supportive staffing

Appendix 7

IMMEDIATE SUPPORT										Table 1
Role/grade	**Improvement**	**SIS**	**Oakwood / Langley**	**Total**	**Days worked**	**Hours worked**	**Cover needed**	**wte reqd**	**£**	**Notes**
Band 3	Activity coordinators based within ward areas - to engage service users in purposeful activity outside of 9-5 hours – data shows that incidents occur out of core hours of activity – to be based in many ward areas.	10	2	12	7	7.5	Yes	20.00	559,044	Langley and Oakwood 5 day only no cover. SIS wards inc enhancements for late shifts
Band 6	Security staff – To provide support to the site and enhance security work on the wards releasing time from ward teams	1	0	1	7	12	Yes	1.00	44,052	Enhancement to existing resource
Band 3	Admin support; 4 CTA's (1 per pathway in SIS, 1 in H+J)	5	1	6	5	7.5	Provided by team	4.00	£103,189	
	2 Staffing coordinators to support DNC				7	7.5	Yes	2.00	£56,209	1 on shift at the weekend
Band 7	Practice Development - to support the development of ward quality and standards	4	0.5	3.5	7	7	Yes	4.50	263,828	Langley and Oakwood 5 day only no cover
Band 6	Move 10 wards to have 2 band 6's this would involve uplift of band 5's – to support consistency within the ward environment, looking at both clinical and operation pressures. This will also provide opportunities within the service for development and possibly reduce retention rates on RN's who apply for opportunities elsewhere.	10	0	n/a	n/a	n/a	n/a	Skill Mix only	95,108	10 wte uplifted from Band 5 to Band 6
Band 5	Skill mix band 3 to 5 per ward - to support ratio of RN's to HCA's in each ward area.	10	0	n/a	n/a	n/a	n/a	Skill Mix only	80,336	10 wte uplifted from Band 3 to 5
Band 3	Leave team – band 3 non registered staff to support and faciliate patient leaves and visits across site	6	0	6	7	7.5	Yes	5.8	176,414	Additional 2 shifts per day
Band 3	*Recovery Team – 7 days per week, 7.5 hrs – To support the service, including ehanced opening times of gym/shop etc	2	0	2	7	7.5	Yes	1.00	29,531	Additional 2 per shift on a late shift and weekends - Immediate 1wte extra
Band 3	Skill mix of reception team – uplift band 2's to a band 3 – to enable work to be supported from the ward to enable a release of time to care in the ward environment	12 to uplift	0	n/a	n/a	n/a	n/a	Skill Mix only	41,967	12 wte uplifted from Band 2 to Band 3
Band 7	To co ordinate and support temp staffing and point of contact on the site, this will improve experince for temporary staff working within service.	1		1	5	7.5	No	1.00	51,203	
Peer support	A peer support supervisor and	1	0	1	5	7.5	No	1.00	33,392	
	6 peer support workers to support patient care on wards	6	0	6	7	7.5	Yes	10.74	326,214	2 Band 3 Peer Support workers per pathwy per shift
IMMEDIATE SUPPORT TOTAL								**51.04**	**1,860,488**	
FUTURE OPPORTUNITIES										
Role/grade	**Improvement**	**SiS**	**Oakwood / Langley**	**Total**	**Days worked**	**Hours worked**	**Cover needed**	**wte reqd**	**£**	**Notes**
Band 3	*Recovery Team – 7 days per week, 7.5 hrs – To support the service, including ehanced opening times of gym/shop etc	2	0	2	7	7.5	Yes	3.00	88,592	Additional 2 per shift on a late shift and weekends - less 1wte included in immediate
Band 5	Psychology support 7 days per week – 3 additional staff – 1 per pathway Additional Band 5 x 3 and to enhance 7days per week working	4	0	4	7	7.5	Yes	3.89	167,344	Additional wte to deliver 7 day working that gives 6 shifts per day
Band 8a	Additional Band 8a to enhance 7 day working				7	7.5	Yes	0.10	57,582	Additional wte to deliver 7 day working that gives 6 shifts per day
	Additional Band 8a for supervision				5	7.5	No	1.00	64,919	
Band 8b	Locality Manager to lead and have oversight of staffing across the whole site	1		1	5	7.5	No	1.00	67,002	
Band 5 and Band 3	Seclusion team 1 x RN & 1 Band 3 days and 1 Band 3 Nights 7 days a week to ensure reviews are consistent and provide excellent quality and safety	3	0	3	7	12	Yes	8.58	302,851	
Band 6/7	SALT band 6 to support team to work 7 days				7	12	Yes	0.06	10,208	1 Qualified SALT per shift
Band 4	SALT band 6 to support team to work 7 days							1.86	71,617	1 Support SALT per shift
Band 4	Staff wellbeing worker to lead and improve welbbeing within the service	1	0	1	5	7.5	No	1.00	29,684	
Band 8a	Modern Matron – currently not in place in H+J, required to support the quality and safety within patient areas could be supported to a full time role by H & J	0	0.5	0.5	5	7.5	No	0.50	33,501	
Band 4	To uplift a band 3 in each ward area to support the physical health in each ward environment - uplift of 18 staff across the site	18	0	n/a	n/a	n/a	n/a	Skill Mix only	88,018	18 wte uplifted from Band 3 to 4
	Observations – currently at 5% / Headroom review									
FUTURE OPPORTUNITIES TOTAL								**20.99**	**981,318**	
OVERALL TOTAL								**72.03**	**2,841,806**	

SIS Immediate Support and Future Opportunities

Appendix 8

Variance	20/21 exc Covid cost	20/21 inc Covid cost		Cost of Covid shifts
ADULT & PICU	**£**	**£**		**£**
Bilsdale	218,067	384,517		166,450
Overdale	105,367	258,019		152,652
Stockdale	159,178	333,926		174,748
Bransdale	181,096	356,780		175,684
Bedale (PICU)	166,547	482,982		316,435
Tees Out of Hours	- 141,037	- 141,037		-
Tunstall	263,801	506,347		242,546
Farnham	181,054	448,773		267,719
Elm	148,695	353,049		204,354
Maple	209,676	362,504		152,828
Cedar PICU	182,946	511,656		328,710
Danby	156,575	257,663		101,088
Esk	- 74,145	35,824		109,969
Ebor	334,051	438,758		104,707
Minster	250,609	530,531		279,922
TOTAL	**2,342,480**	**5,120,292**		**2,777,812**
Variance	**20/21 exc Covid cost**	**Covid cost**		**Cost of Covid shifts**
SIS	**£**	**£**		**£**
Merlin	80,861	98,871		18,010
Nightingale	44,437	73,442		29,005
Linnet	- 11,864	6,294		18,158
Mandarin	214,181	231,541		17,360
Swift	- 60,609	- 20,536		40,073
Sandpiper	316,415	356,369		39,954
Mallard	495,818	509,332		13,514
Newtondale	- 23,463	- 3,705		19,758
Lark	65,582	124,478		58,896
Jay	59,917	81,935		22,018
Brambling	69,666	97,599		27,933
FMH	**1,250,941**	**1,555,620**		**304,679**
Thistle	104,393	140,971		36,578
Northdale	151,717	172,335		20,618
Harrier/Hawk	175,972	197,926		21,954
Kestrel/Kite	187,131	296,651		109,520
Ivy/Clover	27,720	40,300		12,580
FLD	646,933	848,184		**201,251**
TOTAL	**1,897,874**	**2,403,804**		**505,930**

Summary of investment expenditure for immediate additional support by ward

Item no 13

Mental Health Legislation Committee: Key Issues Report		
Report Date:13/03/21		**Report of: Mental Health Legislation Committee**
Date of last meeting: 21/01/21		**Membership Numbers: 4** Quoracy met Apologies: 1 Non-Executive Director
1	**Agenda**	**The Committee continues to meet quarterly. The Committee considered an agenda, which included the following:** • Discharges from Detention • Section 23 (2) – Notification of discharge by nearest relative • Information to Detained Patients Section 132 (MHA 1983) • Section 136 • Seclusion and Segregation • Section 15 MHA Medical and Administrative Scrutiny • MCA/DoLS • CQC report • Revised policies
2a	**Alert**	**The Committee alerts members of the Board that:** • Data revealed some lapses across various wards in providing information to detained patients in Teesside, in particular the wards at Roseberry Park hospital, with a cluster around certain dates. This is being examined in more detail. • The consultation period on reforms to the Mental Health Act arising from the Simon Wesley report ends on 21st April 2021, giving little time for a Trust response to be formulated. Efforts are being made to include Governors, experts by experience and other representatives. • Clinical audit of Section 17 leave forms undertaken between March and August 2020 demonstrated high standards of practice with policy requirements, particularly authorisation forms, however other areas of improvement were identified around aspects of record keeping practices.
2b	**Assurance**	**The Committee assures members of the Board that:** • The Trust continues to provide comprehensive reports and offer clear evidence for recommending continued detention and community treatment and there were a minority of cases in quarter 2 when the Tribunal disagreed with the clinical team. The numbers of patients discharged against clinical recommendation for the Trust is *in line with the national figures.* • The *numbers of discharge by the nearest relative is very low*: during 2020 Hospital Managers received three notifications by the nearest relative for discharge; two were not discharged,

		being barred by the responsible Clinician and the third decided against the intention to discharge. • The numbers of seclusion were relatively low, with 55 episodes of seclusion in Q2, compared to 50 in the previous quarter and no episodes of segregation. Seven patients had multiple episodes of seclusion with one patient secluded six times. No seclusions were related to Covid.		
2c	**Advise**	**The Committee advises members of the Board that:** • There were 126 uses of Section 136 in Q2, 2020, compared to 172 in the previous quarter. Of those, 54 lasted up to four hours, seven over 12 hours and two over 18 hours. There were drops in North Yorkshire (78 down to 45) and Durham and Darlington (30 down to18), with Teesside seeing little change. • Twelve under eighteen's were brought to TEWV as a place of safety in Q2, some with multiple admissions. This data is shared with operational groups. • There are occasions when administrative scrutiny can lead to identifying a fundamental flaw which can invalidate a detention. From January to December 2020 there were 18 occasions when Section 15 could not be used to rectify flaws or insufficiencies (17 in the previous quarter). Fourteen were fundamental flaws such as unsigned applications, using incorrect forms or no patient name on the statutory forms. The numbers are not statistically significant, however there can be an impact on patients. *Assurance was provided that there are adequate systems in place to identify any invalid detentions.* • In January 2021 there were 35 active cases of DoLs across the Trust, mainly at Bankfields and Aysgarth. Due to Covid-19 a number of DoLs have expired as patients have not been coming into hospital for respite. • CQC report to return to pre-pandemic style to include Mental Health Act inspections.		
2d	**Review of Risks**	No new risks to recommend to Board		
Recommendation: to note the report				
3	**Actions to be considered by the Board**	There are no matters to escalate to the Board		
4	**Report compiled by**	Donna Oliver **Deputy Trust Secretary (Corporate)** Elizabeth Moody, **Director of Nursing & Governance**	**Minutes available from**	Donna Oliver, **Deputy Trust Secretary (Corporate)**

Item 14

BOARD OF DIRECTORS

DATE:	**25th March 2021**
TITLE:	**Finance Report for Period 1 April 2020 to 28 February 2021**
REPORT OF:	**Liz Romaniak, Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The report to 28th February 2021 reflects performance within the context of national financial arrangements supporting the NHS to respond to the Coronavirus Pandemic. The Finance report has been adapted to include year to date as well as forecast financial performance in advance of a wider review of Board and Committee reporting, that will include consideration of more Integrated Board Performance Reports.

- **Statement of Comprehensive Income:** The month 11 report shows a year to date surplus of £11.2m; which is £10.4m ahead of the revised plan. The Trust forecasts achieving a surplus of £8.2m, or being £7.6m ahead of a revised required surplus of £0.6m, but notes the potential for further improvement, subject to the national position on annual leave accruals and provisions being confirmed. The position has been discussed with regional colleagues to support system financial management.
- **Capital Programme:** Capital expenditure is £9.8m below plan and forecast to outturn £7.0m below plan at the end of March. This reflects the following material variances:
  - The benefit from a £4.05m VAT rebate following completion of the Foss Park Hospital build, partially offset by estates costs that were prioritised in-year.
  - A successful bid for £4.5m cash-backed national Mental Health Programme funding for planned Children and Young People capital costs received during February.
  - Delays in construction projects including at Kings Park and equipment purchases.

Cash: Balances were £112.6m as at 28th February and included £31.8m income received in advance through national funding arrangements to support prompt supplier payments. It has been confirmed that no further cash advances will be received.

Whilst national financial planning arrangements have been deferred into quarter 1 (possibly quarter 2) of 2021/22, progress is being made in a number of key areas including preparatory run-rate analysis, consideration of transformational costs to progress key strategic priorities and a review of items funded through the Strategic Change Fund.

Recommendations:

The Board of Directors is requested to receive the report, consider the issues and risks raised and any related further assurances needed.

MEETING OF:	**Board of Directors**
DATE:	**25th March 2021**
TITLE:	**Finance Report for Period 1 April 2020 to 28 February 2021**

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for the eleven months 1 April 2020 to 28 February 2021.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report will enable the Board of Directors to monitor the Trust's key financial duties and key performance indicators (KPIs) which are both statutory requirements. Appendix 1 provides an overview of the Trust's KPIs for the year to date and forecast performance to 31st March 2021.

2.2 NHS Improvement's (NHSI) Use of Resources Rating (UoRR) evaluates Trusts based on ability to service debt, liquidity, Income and Expenditure (I&E) margin, achievement of planned I&E margin, and agency expenditure.

2.3 National financial arrangements have operated throughout 2020/21 to support the NHS in responding to the Covid-19 Pandemic. In the first six months (April to September 2020) the Trust followed national guidance for Covid-19 emergency planning and received a top up of income, including for recovering Covid-19 costs, each month in order to break-even. For the remaining months (October 2020 to March 2021) the Trust submitted an updated revenue forecast of a £2.0m deficit outturn. This became the Trust's planned deficit for 2020/21. The Trust's forecast surplus was revised, by agreement with NHSI during November, following notification of the receipt of £2.6m additional clinical income, to a £0.6m surplus. This is the surplus against which we now therefore track performance.

3.1 <u>Key Performance Indicators</u>

The UoRR for the Trust is assessed as 1 for the period ending 28 February 2021, representing the lowest assessment of risk.

Appendix 1 provides a summary of all KPIs for the period ending 28 February 2021 and forecast year end outturn position.

3.2 <u>Statement of Comprehensive Income – Year to date</u>

In the first six months of the financial year (April to September) national NHS financial arrangements supporting Covid-19 emergency planning provided a top up of income each month in order that the Trust broke even each month.

Since October, financial performance has been measured against an agreed financial plan; currently a surplus of £0.6m. Performance for the period ending 28 February 2021 shows a surplus of £11.2m, which is £10.4m ahead of plan and is summarised in table 1 below:

Table 1	Annual Plan			Year to Date		YTD
	M1-6	M7-12	Total	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000
Income From Activities	175,422	193,311	**368,733**	337,330	340,999	-3,669
Covid Top Up income	8,313		**8,313**	8,313	7,760	553
Other Operating Income	8,969	7,801	**16,770**	15,443	18,252	-2,809
Total Income	**192,704**	**201,112**	**393,816**	**361,086**	**367,011**	**-5,925**
Pay Expenditure	-153,727	-159,627	**-313,354**	-286,701	-283,250	-3,450
Non Pay Expenditure	-33,763	-35,730	**-69,493**	-64,174	-65,759	1,585
Depreciation and Financing	-5,214	-5,153	**-10,367**	-9,455	-6,821	-2,634
Surplus / (Deficit)	**0**	**602**	**602**	**756**	**11,180**	**-10,424**

Income from activities is ahead of plan largely due to further investment from commissioners in relation to mental health investment standards and service development funding across various clinical localities which was not anticipated in the trust's plan for October 2020 to March 2021.

Other operating income is ahead of plan reflecting receipt of £1.8m additional trainee funding and an updated Learning Development Agreement not anticipated in the revised plan. The Trust also received £0.4m one-off income relating to a previously unresolved contract dispute.

Pay expenditure is lower than plan due to Covid-19 related expenditure being less than anticipated (£0.8m) and continued vacancies where recruitment was expected (£2.6m).

Depreciation and Financing expenditure is less than planned and includes the on-off benefit from reduced PDC dividend payable (£2.2m) associated with the benefit of advance block cash payments; reflected in the financial ledger in February. This follows confirmation of the national position to support consistency and annual accunts consolidation.. Depreciation (£0.5m) incorporates slippage in the capital programme.

3.3 Statement of Comprehensive Income - Forecast Outturn

The Trust anticipates a forecast surplus of £4.6m at the end of the financial year, which is £4.0m ahead of our revised required position of £0.6m surplus, but notes the potential for improvement, subject to the national position on annual leave accruals and provisions being confirmed. This is summarised in table 2 below:

Table 2	Plan				Forecast	
	M1-6	M7-12	Add. Income	Total	Locality Forecast	Variance from plan
	£0	£0	£0	£0	£0	£0
Income From Activities	175,422	190,711	2,600	**368,733**	373,360	-4,627
Covid-19 Top Up income	8,313			**8,313**	7,760	553
Other Operating Income	8,969	7,801		**16,770**	18,499	-1,729
Total Income	**192,704**	**198,512**	**2,600**	**393,816**	**399,619**	**-5,803**
Pay Expenditure	-153,727	-159,627		**-313,354**	-312,757	-597
Non Pay Expenditure	-33,763	-35,730		**-69,493**	-71,411	1,918
Depreciation and Financing	-5,214	-5,153		**-10,367**	-7,244	-3,123
Surplus / (Deficit)	**0**	**-1,998**	**2,600**	**602**	**8,207**	**-7,605**

Further potential upsides relate to income from specialist commissioning contracts, income to support trainee costs, reconciliation of facilities related cost "true ups" and potential slippage on Covid cost projections. The Trust may also benefit from national decisions pending in relation to annual leave and provisions.

The Trust identified a number of posts that would be required immediately to support the 'phase 1' response to the Pandemic and recruitment activities commenced in the early autumn of 2020. To date a large proportion of posts advertised have been recruited from staff already employed by the Trust, with several recruitment episodes yet to conclude. Associated under spending will be partly offset by additional temporary staffing, including agency, required to meet increased service demand and cover staff shortages including those due to sickness and isolation.

The Trust has taken the opportunity to fast-track some of the 'Build Back Better' programme priorities and to address backlog and other pressing and/or Covid-19 issues. Projected costs have been included in the forecast.

3.4 Cash Releasing Efficiency Savings (CRES)

Performance against the 2020/21 CRES target is shown in Table 3 below, with forecast delivery being £589k behind plan at the end of the financial year. The Trust's Finance Sustainability Board will keep this situation under review and co-ordinate through 2021/22 financial planning activities. Delays in delivery are being mitigated by non-recurrent underspends.

Table 3: Cash Releasing Efficiency Scheme Performance 2020/21	**2020/21 Cumulative Target**	**2020/21 Identified Recurrent Schemes**	**2020/21 Identified Non Recurrent Schemes**	**2020/21 Total Identified Schemes**	**2020/21 Variance from Target**
Locality	**£000**	**£000**	**£000**	**£000**	**£000**
Chief Operating Officer	**3,457**	3,322	-807	**2,515**	941
Corporate and EFM	**824**	678	253	**931**	-107
Total identified and approved recurrent CRES	**4,281**	**4,000**	**-554**	**3,446**	**835**
Trust Wide Schemes					
Revaluation of Assets - Depreciation & PDC	**-154**	607	-515	**92**	-246
Total identified non recurrent schemes	**-154**	**607**	**-515**	**92**	**-246**
Total identified and approved recurrent CRES	**4,127**	**4,608**	**-1,069**	**3,538**	**589**

3.5 Capital

Capital expenditure is £9.9m lower than plan, and is forecast to outturn £7.0m below plan. This reflects the following material variances:

- The benefit from a £4.0m VAT rebate following completion of the Foss Park Hospital new build, partially offset by estates costs that were prioritised and fast-tracked in-year.
- £4.5m cash-backed National Mental Health Programme support for planned Children and Young People capital expenditure received in February.
- Delays in construction projects including Kings Park; £0.6m and IT equipment purchases; £1.3m.

The forecast outturn assumes the receipt of IT network switches which have been ordered (£2,428k) and are expected to be delivered during March. If the

order is delayed beyond March 2021 capital expenditure would reduce and the order would generate a pressure on the 2021/22 capital resource envelope.

3.6 Workforce

Table 4 below shows performance on some of the key financial drivers identified by the Board.

Table 3	Pay Expenditure as a % of Pay Budgets						
Tolerance	Tolerance February-21	September	October	November	December	January	February
Establishment (a) (90%-95%)	94.89%	93.03%	93.43%	93.37%	93.98%	93.05%	94.89%
Agency (b)	2.60%	2.44%	2.46%	2.49%	2.51%	2.53%	2.60%
Overtime (c)	1.00%	1.15%	1.15%	1.19%	1.23%	1.22%	1.27%
Bank & ASH (flexed against establishment) (100%-a-b-c)	1.51%	3.29%	3.29%	3.35%	3.41%	3.43%	3.40%
Total	**100.00%**	**99.92%**	**100.34%**	**100.40%**	**101.13%**	**100.22%**	**102.16%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for overtime and 2.6% for agency, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For February 2021 the tolerance for Bank and ASH is 1.51% of pay budgets.

Prior to the Pandemic, NHS Improvement monitored agency expenditure against a capped annual target of £7.6m (or 2.6% of pay budgets). Agency expenditure to date is £7.5m which is £0.5m above the cap for the period ending 28 February 2021, with expenditure across all localities.

Whilst flexible staffing costs have increased so far in quarter 4 and would exceed the pre-Covid agency cost cap, expenditure is not as high as had previously been expected. The trust has also benefited from recruitment of 83 students undertaking paid placement arrangements that support the Covid-19 response; this explains the increase in the establishment metric in table 3.

Nursing and Medical agency expenditure accounts for 98% of total agency expenditure, with staffing used to cover vacancies, sickness and isolation and support enhanced observations with complex clients.

Excluding that used for Covid-19 related activities, agency expenditure is below the agency expenditure cap. The Trust continues to work to improve this position on a recurrent basis.

3.7 Statement of Financial Position

The following key issues impact the Trust's Statement of Financial Position for the period ending 28 February 2021.

Total **cash** at 28 February 2021 is £112.6m; this is £50.5m ahead of plan and is largely due:

- to income relating to future period block contract income – (£31.7m);
- to the required improvement in plan (£2.6m);
- to the favourable revenue plan variance (£10.4m);
- to receipt of PDC (cash) backed national Mental Health Programme capital funding for Children and Young People (£4.5m);

- The remaining balance relates to movements in working capital.

A refreshed cash flow forecast and 5 year capital plan / financing estimate is being progressed to take into account current cash forecasts and the revised draft 5-year capital plan.

Accounts Receivable (amounts owed to the Trust) remain high during February and include aged debts of £8.4m with 21%, or £1.8m being over 90 days and not currently provided for within the Trust's bad debt provision. Of the amount outstanding over 90 days £1.085m comprises five NHS debtors, with all expected to be resolved before the financial year end.

3.8 Use of Resources Risk Rating (UoRR) and Indicators

3.8.1 The UoRR is impacted by Covid-19 and national monitoring is currently suspended. However the Trust has continued to assess the UoRR which is a rating of '1' for the period ending 28 February 2021. Table 5 below shows the performance over each of the metrics.

Table 4: Use of Resource Rating at 28 February 2021

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

Actual performance 28 February 2021	Actual		YTD Revised Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	4.45x	1	1.69x	2	
Liquidity	52.5	1	33.08	1	
I&E margin	3.1%	1	0.2%	2	
I&E margin distance from plan	2.8%	1	0.0%	1	
Agency expenditure (£000)	£7,451k	2	£6,967k	1	
Overall Use of Resource Rating		**1**		**1**	

3.8.2 The **capital service capacity** metric assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 4.45x (can cover debt payments due 4.45 times), which is ahead of plan and is rated as a 1.

3.8.3 The **liquidity** metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is 52.5 days; this is ahead of plan and is rated as a 1.

3.8.4 The **Income and Expenditure (I&E) margin** metric assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 3.1%, which is ahead of plan and is rated as 1.

3.8.5 The **I&E margin distance from plan ratio** metric assesses the I&E surplus/deficit relative to planned performance. The Trust I&E margin distance from plan is 2.8% which is rated as a 1 and is on plan.

3.8.6 The **agency expenditure** metric assesses agency expenditure against a capped target for the Trust. Agency expenditure is in breach of the capped target by £0.5m (or 7%) inclusive of Covid-19 related costs and is behind plan and rated as a '2'.

4. IMPLICATIONS:

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

5. RISKS:

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

5.2 There is a risk that projected costs may not be fully expended by 31st March 2021, including schemes that are being fast-tracked in quarter 4. This, and the outcome of a national review of issues including annual leave accruals and provisions to ensure consolidation consistency, could result in a further 'upside' improvement in the forecast surplus.

5.3 To enable continued focus on the pandemic, annual financial planning activities for 2021/22 have been suspended nationally. Guidance is expected to be issued in early April and national block funding arrangements are being extended into the first quarter of 2021/22, with national plan submissions now expected to be required in June 2021.

In the absence of detailed guidance and resource assumptions high level run rate financial forecasts were shared with the regional finance team and will be finalised on 19th March. Forecasts were reviewed by the Senior Leadership Group and Resources Committee and support a 'preliminary' Trust Financial Plan paper that will be considered by the Board in Private in March 2021. Plans will be reviewed and submitted for Board consideration during quarter one following confirmation of national planning guidance and funding flows.

6. CONCLUSIONS:

6.1 For the period ending 28 February 2021 the Trust outturn is a surplus of £11.2m which is £10.4m ahead of the revised forecast surplus of £0.6m. The Trust has taken the opportunity afforded by receipt of Covid-19 and growth funding allocated via the ICS to fast-track some of the Build Back Better programme priorities, address backlog and other pressing and/or Covid-19 issues.

6.2 The Trust anticipates a forecast surplus of £8.2m at the end of the financial year, although further upsides scenarios could improve this position further, most notably the national position on annual leave and provisions.

6.3 The amount of CRES identified for the financial year is behind plan due to the need to focus on the Pandemic response. Delays in delivery are being mitigated by non-recurrent underspends. Plans to meet the required target in

future years will be monitored by the Trust's Finance Sustainability Board and planning activities recommence.

6.5 Financial planning activity for 2021/22 has been suspended nationally to allow continued focus across the NHS on the vital pandemic response. Funding allocations are not yet known, but national financial arrangements currently operating will roll forward into quarter one of the new financial year.

6.4 The UoRR for the Trust is assessed as 1 for the period ending 28 February 2021 and is in line with plan.

7. RECOMMENDATIONS:

7.1 The Board of Directors is requested to receive the report, consider the issues and risks raised and any related further assurances needed.

Liz Romaniak
Director of Finance of Information

Appendix 1 – Key Performance Indices

Surplus variances are shown as negative	Year to date Plan	Actual	Variance	RAG	Prior Month Variance	RAG	Forecast Plan	Actual	Variance	RAG
I&E (Surplus) / Deficit £m	-0.8	-11.2	-10.4	●	-8.1	●	-0.6	-4.6	-4.0	●
EBITDA £m	-10.2	-18.0	-7.8	●	-6.5	●	-11.0	-13.8	-2.8	●
Net Surplus Ratio %	0.2%	3.0%	-2.8%	●	-2.4%	●	0.2%	1.2%	-1.0%	●
EBITDA Margin %	2.8%	4.9%	-2.1%	●	-1.9%	●	2.8%	3.4%	-0.8%	●
Income £m	-361.1	-367.0	-5.9	●	-4.3	●	-394.2	-399.5	-5.4	●
Pay Expenditure £m	286.7	283.3	-3.5	●	-2.9	●	313.2	313.0	-0.2	●
Non Pay Expenditure £m	64.2	65.8	1.6	◆	0.7	◆	70.0	72.8	2.8	◆
Non Operating Expenditure £m	9.5	6.8	-2.6	●	-1.6	●	10.4	9.1	-1.2	●
Capital Expenditure £m	32.7	22.8	-9.8	●	-9.0	◆	33.6	26.6	-7.0	●
Capital Service Cover	1.69x	4.45x	-2.76x	●	-1.83x	●	1.66x	2.5x	-0.93x	●
Liquidity Days	33.1	52.5	-19.4	●	-11.4	●	36.1	39.5	-3.4	●
I&E Margin	0.2%	3.1%	-2.9%	●	-2.4%	●	0.2%	1.2%	-1.0%	●
Variance from I&E Margin plan	0.0%	2.8%	2.8%	◆	-2.4%	●	0.0%	0.0%	0.0%	●
Agency Expenditure £m	7.0	7.5	0.5	◆	0.3	◆	7.6	9.3	1.7	◆
CRES £m	4.1	3.5	0.6	◆	0.6	◆	4.1	3.5	0.6	◆
Cash Balances £m	62.1	112.6	-50.5	●	-45.1	●	61.0	74.3	-13.3	●
Total debt over 90 days	5.0%	31.2%	26.2%	◆	29.4%	◆	5.0%	5.0%	0.0	●
BPPC NHS invoices paid < 30 days	95.0%	100.0%	-5.0%	●	-1.4%	●	95.0%	100.0%	-5.0%	●
BPPC Non NHS invoices paid < 30 days	95.0%	95.2%	-0.2%	●	0.8%	●	95.0%	95.2%	-0.2%	●

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 15

FOR GENERAL RELEASE

MEETING OF THE BOARD OF DIRECTORS

DATE:	**25th March 2021**
TITLE:	**Board Performance Dashboard as at 28th February 2021**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communication**
REPORT FOR:	**Assurance**

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

Executive Summary:

This is the Board level Performance Dashboard for the period ending **28th February 2021**. We have been able to apply Statistical Process Control (SPC) Charts to **18** of the 21 measures. Three measures are finance related and detailed narrative has been provided for these.

Key Issues

Having reviewed the variation and assurance icons in addition to the latest financial year to date performance there has been **5** areas of concern identified and **4** areas which require additional monitoring. Details on why these areas have been highlighted are provided in the table below with further information in Appendix A. Exceptions at Locality level are also noted within Appendix A. Where discussions have taken place with Operational Services and other Corporate Departments on the key areas of concern more detailed information on these can be found in Appendix D.

Key Areas of Concern:

4)	Percentage of patients surveyed reporting their overall experience as excellent or good	This issue was first identified in the September Board Report. Whilst the SPC chart shows common cause variation (no significant change) it also shows that the standard will be met and sometimes missed due to random variation. Given that this is a key measure of quality and that the latest Year To Date (YTD) actual is also below the standard this is an area of concern

		that we need to investigate further. Appendix A provides further information on this and a further update on the actions identified is due in May 2021.
6)	% of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind	This issue was first identified in the September Board Report. This is a key outcome measure which is indicating special cause variation of particular concern and that the standard will be met and sometimes missed due to random variation. In addition the latest YTD actual is also below the standard therefore we need to investigate further. Appendix A provides further information on this and Appendix D provides an update on the actions identified for one of the localities. Whilst our actual performance against the Trust measure isn't at the standard we would want it to be, from the latest data available (on the number of paired measures (as opposed to the amount of change made), we are continuing to perform better from a national benchmarking perspective
9)	The percentage of new unique patients referred with an assessment completed (2 months behind)	This issue was first identified in the September Board Report. This is a key measure of quality and effectiveness which is indicating special cause variation of particular concern and remains within the lower process limit therefore we need to investigate further. Appendix A provides further information on this and further updates on the actions identified are due next month.
10)	The percentage of new unique patients referred and taken on for treatment (3 months behind)	This key measure of quality and effectiveness has continued to indicate special cause variation of particular concern and is now on the lower process limit therefore we need to investigate further. Appendix A provides further information on this and Appendix D provides an update on the actions identified for one of the localities.
18)	Percentage Sickness Absence Rate (month behind)	This key workforce measure is now indicating special cause variation of particular concern (previously common cause) with the latest data point above the upper process limit. It also indicates that we will consistently fall short of the standard. We have therefore moved this from "additional monitoring" into an area we need to investigate further. Appendix A provides further information on this and further updates on the actions identified are due next month.

Measures which require additional monitoring:

2)	Percentage of patients starting treatment within 6 weeks of an external referral	The SPC is now showing **special cause improvement** (previously special cause variation of particular concern) and that the standard will be met and sometimes missed due to random variation; however the latest YTD actual remains above the standard (positively). Two of the localities are within

		common cause variation (no significant change); however show overall deterioration in the last 5 to 7 months. Given this is a key measure of quality this will be subject to "additional monitoring". Appendix A provides further information on this and Appendix D provides an update on the actions identified for one of the localities.
3)	The total number of inappropriate OAP days over the reporting period (rolling 3 months)	Whilst this key measure of quality is indicating **special cause improvement** within the SPC chart, the chart also indicates that there is no assurance that the standard will be delivered consistently as this stage. There is also **special cause variation of particular concern** in one of the localities therefore this will now be subject to additional monitoring. Appendix A provides further information on this
5)	The percentage of Serious Incidents which are found to have a root cause or contributory finding	Whilst this key measure of quality is indicating **common cause variation (no significant change)** within the SPC chart, the chart also indicates that there is no assurance that the standard will be delivered consistently as this stage. There is also **special cause variation of particular concern** in one of the localities therefore this will now be subject to additional monitoring. Appendix A provides further information on this
12)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	The SPC chart for this measure first indicated **special cause improvement** in the November Board report and continues with the latest data. The latest YTD actual is below the standard (positively); however the latest data point is now on the mean. The SPC chart also indicates that the standard will be met and sometimes missed due to random variation and feedback from Operational Services is that bed pressures continue in some specific areas. During February there were also a number of ward closures due to Covid outbreaks which have impacted on occupancy. Given this is a key measure of effectiveness, this is an area that we are continuing to undertake additional monitoring. Occupancy is likely being supported by the special cause improvement in the number of patients occupying a bed with a LoS from admission less than 90 days (measure 13). Appendix A provides further information on this including when a more detailed update will be provided.

Positive assurance:

1)	Percentage of patients seen within 4 weeks for a 1st appointment following	This key measure of quality is continuing to provide positive assurance as indicated by the **special cause improvement** displayed within the SPC chart,

	an external referral	although the chart indicates that there is no assurance that the standard will be delivered consistently as this stage.
13)	No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	This key measure of quality and effectiveness is continuing to provide positive assurance as indicated by the **special cause improvement** displayed within the SPC chart, although the chart indicates that there is no assurance that the standard will be delivered consistently as this stage.
16)	Percentage of staff in post with a current appraisal	This key workforce measure is continuing to provide positive assurance as indicated by the **special cause improvement** displayed within the SPC chart, although the chart indicates that we will consistently fall short of the standard. As previously reported, there have been a number of extensions to the time allowed to complete appraisal (linked to the pressures caused by the pandemic) which were approved by Gold Command which have been implemented in the measure.

Other issues/points to note:

17)	Percentage compliance with ALL mandatory and statutory training (snapshot)	We first reported in the December Board Report a number of issues in relation to the accuracy of the data being reported. The issues were investigated and accuracy around courses for specific staff banding corrected; however there continued to be some complex changes regarding new/revised courses which required further work. In addition the extensions to the time allowed to complete mandatory and statutory training (linked to the pressures caused by the pandemic) approved by Gold Command hadn't been implemented as the priority was resolving the complex changes. All the required changes have now been implemented for this key workforce measure and the data has been refreshed where appropriate. Based on the work undertaken we believe that the position reported is now accurate.

NHS Oversight Framework

We reported previously that in Q3 we failed to achieve the national standard for *IAPT Recovery* as a Trust due to not achieving the standards in County Durham and Tees Valley CCGs. Based on the data pertaining to January-February 21 (part Q4) we have **positive assurance** of achievement at Trust level and for all core CCGs.

Appendices

- **Appendix A** is the summary dashboard showing all the measures with further detail (where appropriate)
- **Appendix B** provides the individual Trust and Locality Level SPC charts and the variation/assurance icons associated with these
- **Appendix C** provides an explanation for the symbols used in the table/SPC charts
- **Appendix D** provides detailed information on the areas of concern highlighted in this report including those subject to additional monitoring (where appropriate)

Recommendations:

It is recommended that the Board:

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

2. Note the following recommendations within Appendix D:

   a) Percentage of patients starting treatment within 6 weeks of an external referral (TD02) - *To note the deep dive from the Tees Locality and the actions to be progressed*

   b) The total number of inappropriate OAP days over the reporting period (rolling 3 months) (TD03) - *To note the deep dive from the Durham & Darlington Locality and the actions to be progressed*

   c) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) (TD06) - *To note the deep dive from the Durham & Darlington Locality and the actions to be progressed*

   d) The percentage of new unique patients referred and taken on for treatment (3 months behind) (TD10) - *To note the progress made by the Tees Locality and the further actions to be progressed*

3. Note the following measures providing positive assurance:

   - Percentage of patients seen within 4 weeks for a 1st appointment following an external referral) (TD01)

   - No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot (TD13)

   - Percentage of staff in post with a current appraisal (TD16)

TRUST Dashboard Summary

Tees, Esk and Wear Valleys
NHS Foundation Trust

Quality

Measure Name	Variation Ending Feb - 2021	Assurance Ending Feb - 2021	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral			90.00%	93.96%	90.00%	
2) Percentage of patients starting treatment within 6 weeks of an external referral			60.00%	66.74%	60.00%	Durham and Darlington are demonstrating no significant change (common cause variation); however there is a continuous decline in the last 7 data points and they are below the standard and the mean. Following initial analysis, more detailed work was completed at specialty and team level and shared with the locality to better understand their positions and whether this is an actual area of concern. This was shared with the Board previously and an update on the actions identified will be provided next month. Tees are demonstrating no significant change (common cause variation); however there is a continuous decline in the last 5 data points and they are now below the standard and the mean. This information was shared with the locality to better understand their position and whether this is an actual area of concern and update on this is included in Appendix D.
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)			1,833	1,565	1,833	Durham and Darlington are demonstrating special cause variation of particular concern therefore this was an area we needed to investigate further. This information was shared with the locality to better understand their position and whether this is an actual area of concern and update on this is included in Appendix D.
4) Percentage of patients surveyed reporting their overall experience as excellent or good			94.00%	90.53%	94.00%	Patient Experience has been impacted by Covid in relation to the restrictions that had to be put in place as part of National Guidance; however given the SPC charts are indicating no significant change (common cause variation) at Trust and Locality Level, we agreed we needed to undertake a deep dive to understand the position better and what could be done to improve the position given this is a key measure of quality. The Quality & Safety Cell undertook a deep dive which was shared with the Board previously and an update on the actions identified was shared with the Senior Leadership Group last month. A further update will be provided in May 2021.
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding			32.00%	37.42%	32.00%	Tees are demonstrating special cause variation of particular concern therefore is an area we needed to investigate further. Additional analysis will be completed and shared with the Patient Safety team and the locality to better understand this position. A further update will be provided in April 21.
6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind			60.00%	49.38%	60.00%	Durham and Darlington Locality is now indicating no significant change (common cause variation) and that the standard will be met and sometimes missed due to random variation (previously an area of concern). The latest data point is below the standard and on the lower process limit. This information was shared with the locality to better understand their position and whether this is an actual area of concern and an update on this is included in Appendix D. Tees Locality is indicating special cause variation of particular concern and needing action and that the standard will be met and sometimes missed due to random variation. The latest data point is also below the standard. North Yorkshire & York locality is also indicating special cause variation of particular concern and needing action and that the standard will be met and sometimes missed due to random variation. The latest data point is also below the lower process limit. This information was shared with both localities to better understand their positions and whether this is an actual area of concern and these have been shared with the Board previously. An update on the actions identified will be provided next month.
7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind			65.00%	68.23%	65.00%	

Activity

Measure Name	Variation Ending Feb - 2021	Assurance Ending Feb - 2021	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
8) Number of new unique patients referred				75,155		

TRUST Dashboard Summary

Tees, Esk and Wear Valleys NHS Foundation Trust

Measure Name	Variation Ending Feb - 2021	Assurance Ending Feb - 2021	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
9) The percentage of new unique patients referred with an assessment completed (2 months behind)				69.17%		Forensics Locality is indicating no significant change (common cause variation) following 18 consecutive data points demonstrating special cause variation of particular concern (low) and needing action. Having reviewed the underlying data for this we have identified that there is special cause improvement (an increase) within the denominator which is the number of new unique referrals (linked to above measure). This information was shared with the locality to better understand their position and whether this is an actual area of concern and this was shared with the Board previously. An update on the actions identified was shared with the Senior Leadership Group last month and a further update will be provided next month. North Yorkshire & York Locality is continuing to indicate special cause variation of particular concern (low) and needing action. Having reviewed the underlying data there is no indication of significant change (common cause variation) in the data. This information was shared with the locality to better understand their position and whether this is an actual area of concern and this was shared with the Board previously. The remaining action was to include telephone contacts for MHSOP and LD services trust-wide. This change has been made and is currently going through impact assessment before being implemented in this report. This change will be reflected in next month's report.
10) The percentage of new unique patients referred and taken on for treatment (3 months behind)				32.20%		Durham and Darlington Locality is indicating special cause variation of particular concern (low) and needing action. This information will be shared with the locality to better understand their position and whether this is an actual area of concern. An update on this will be included in next month's report. Tees Locality is continuing to indicate special cause variation of particular concern (low) and needing action. This information was shared with the locality to better understand their position and whether this is an actual area of concern and this has been shared with the Board previously. An update on the actions identified was shared with the Senior Leadership Group last month and a further update is included in Appendix D. Forensic Services are continuing to demonstrate no significant change (common cause variation) previously special cause variation of particular concern. This information was shared with the locality to better understand their position and whether this is an actual area of concern and this has been shared with the Board previously. An update on the actions identified was shared with the Senior Leadership Group last month and a further update will be provided next month.
11) Number of unique patients discharged (treated only)				30,418		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)			90.00%	77.91%	90.00%	Following previous deep dive work at Trust and Locality level, bed occupancy is now being monitored weekly using SPC at ward level by the Corporate Performance Team. Currently there are areas of concern highlighted on a male ward in Durham and Darlington and one in North Yorkshire and York. All female wards are demonstrating no significant change (common cause variation), however are all above the mean and standard. During February there were also a number of ward closures due to Covid outbreaks which have impacted on occupancy. A Trust wide bed event was planned to take place across two ½ days in February, however this has been postponed due to pressures within the Trust in relation to the Pandemic. Once a new date is confirmed and update will be provided to the Board.
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot			61	39	61	
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)			9.90%	10.30%	9.90%	

Workforce

Measure Name	Variation Ending Feb - 2021	Assurance Ending Feb - 2021	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
15) Finance Vacancy Rate				-5.11%		
16) Percentage of staff in post with a current appraisal			95.00%	96.48%	95.00%	As previously reported, there have been a number of extensions to the time allowed to complete appraisal (linked to the pressures caused by the pandemic) which were approved by Gold Command. The extensions have now been implemented in the measure and the data has been refreshed for the relevant time period. The data being reported is now a more accurate reflection of the position.
17) Percentage compliance with ALL mandatory and statutory training (snapshot)			92.00%	92.15%	92.00%	

TRUST Dashboard Summary

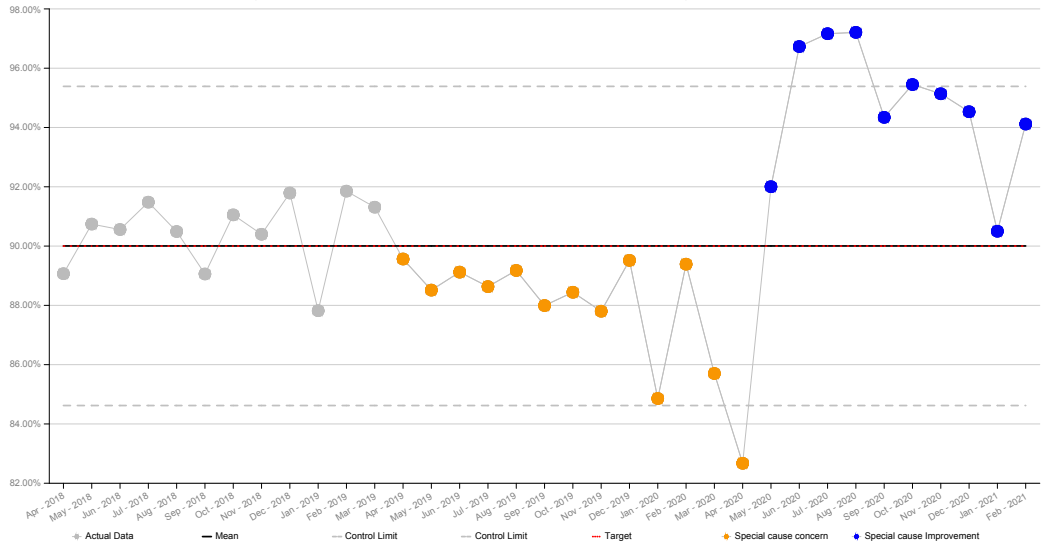
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Measure Name	Variation Ending Feb - 2021	Assurance Ending Feb - 2021	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
18) Percentage Sickness Absence Rate (month behind)			4.30%	5.09%	4.30%	Durham and Darlington are continuing to demonstrate no significant change (common cause variation) with the latest data point below the upper process limit. Identified as an area of concern in the January report (data ending December 20); this information was shared with the locality to better understand their position and whether this is an actual area of concern and an update was provided to the Senior Leadership Group last month. A number of actions were identified and an update on this will be provided next month. Forensics are indicating special cause variation of particular concern with the latest data point above the mean, standard and upper process limit. An action plan was developed in June 2020 and since then sickness absence rates have been closely monitored each month. Within the service there has been an increase in COVID related sickness, with the highest levels of absence for the past year. The overall number of episodes of sickness not related to COVID is also high with an increase in long term sickness with an equal number related to physical health and mental health; although the numbers of work related sickness absence has not increased. This measure will continue to be closely monitored in order to identify if any further actions are needed. North Yorkshire and York are indicating special cause variation of particular concern with the latest data point above the mean, standard and upper process limit. This information will be shared with the locality to better understand their position and whether this is an actual area of concern. An update on this will be included in next month's report. A Trust wide discussion will take place with HR to understand the current sickness levels in more detail and whether any additional actions are required at this time.

Money

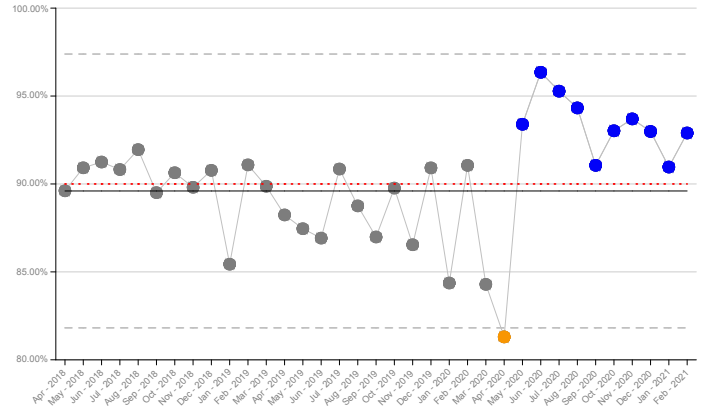
Measure Name	Plan (YTD)	Actual (YTD)	Comments
19) Delivery of our financial plan (I and E)	-756,000	-10,425,005	Statement of Comprehensive Income for month 11 report shows a year to date surplus of £11.2m, which is £10.4m ahead of the revised plan. The Trust forecasts achieving a surplus of £4.6m, or being £4.0m ahead of a revised required surplus of £0.6m, but notes further likely upsides equivalent to £3.6m and the potential for national income towards annual leave and provisions. These have been discussed with regional colleagues to support system financial management.
20) CRES delivery	3,782,779	3,243,344.29	Identified Cash Releasing Efficiency Savings as at 28 February 2021 is £3,243k and is £539k behind plan. The Trust's Finance Sustainability Board will keep this situation under review and co-ordinate through 2021/22 financial planning activities. Delays in delivery are being mitigated by non-recurrent underspends.
21) Cash against plan	62,121,000	112,587,757	Cash balances at 28th February are £112,588k and include £30,856k income received in advance to support prompt supplier payments under national funding arrangements. It has been confirmed that prepayments will cease at the financial year end.

1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral - TRUST

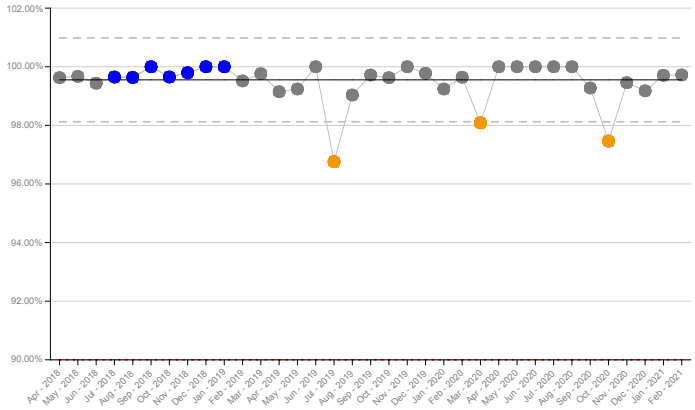


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	H	?	90.00%	95.39%	84.62%
DURHAM AND DARLINGTON	H	?	89.60%	97.39%	81.82%
FORENSIC SERVICES		P	99.55%	100.98%	98.12%
NORTH YORKSHIRE AND YORK	H	?	84.83%	92.32%	77.34%
TEESSIDE	H	?	93.28%	98.05%	88.51%

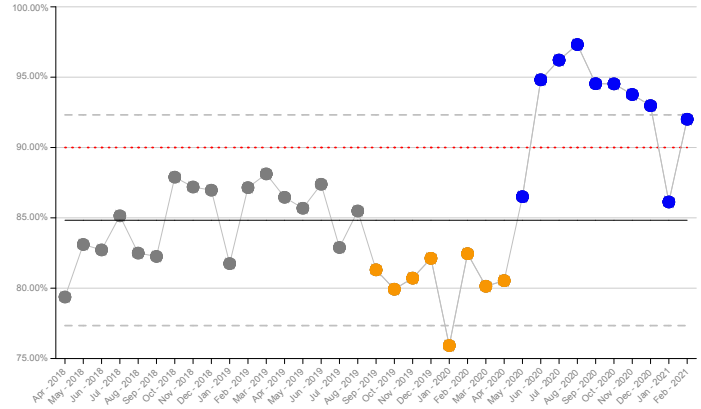
DURHAM AND DARLINGTON



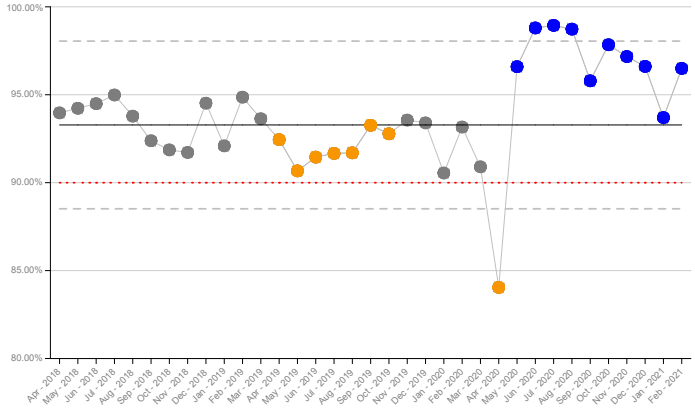
FORENSIC SERVICES



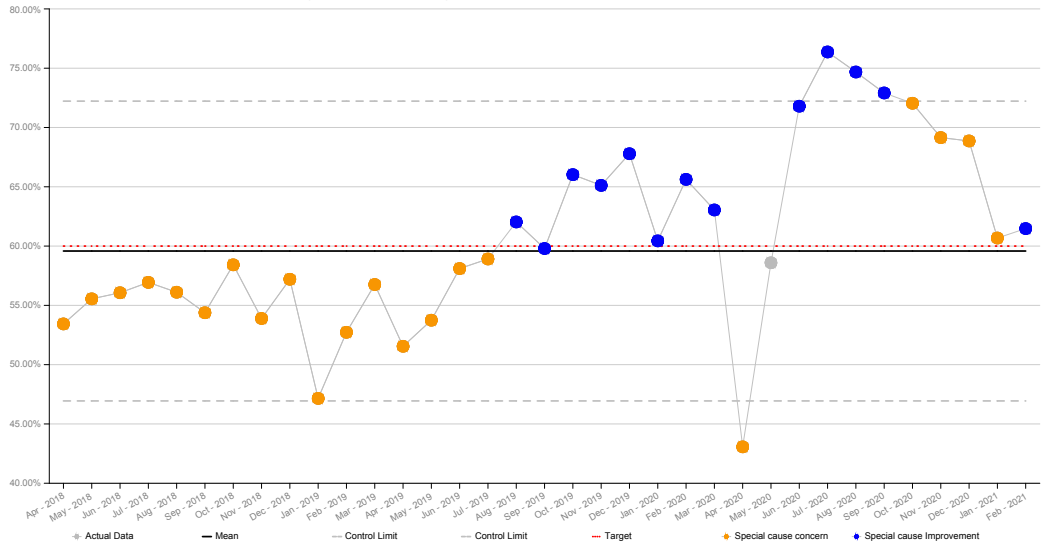
NORTH YORKSHIRE AND YORK



TEESSIDE

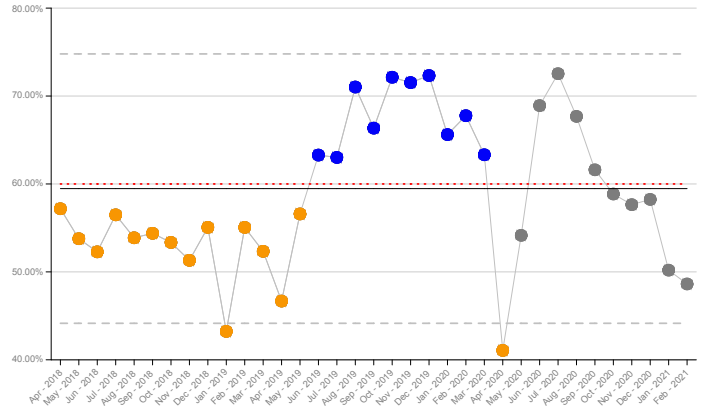


2) Percentage of patients starting treatment within 6 weeks of an external referral - TRUST

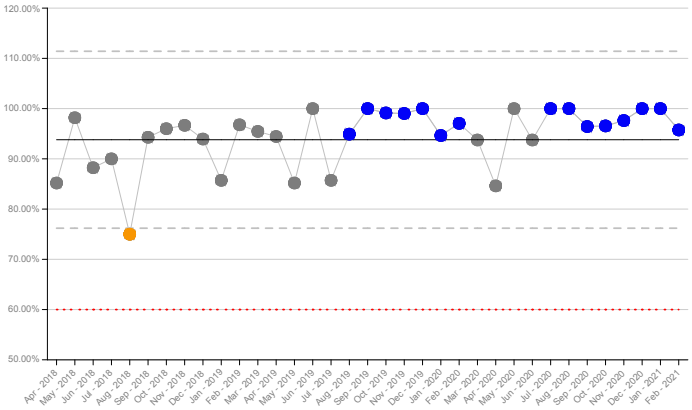


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	H	?	59.58%	72.22%	46.94%
DURHAM AND DARLINGTON		?	59.47%	74.79%	44.15%
FORENSIC SERVICES	H	P	93.80%	111.41%	76.19%
NORTH YORKSHIRE AND YORK	H	?	62.36%	75.85%	48.87%
TEESSIDE		?	61.21%	76.02%	46.40%

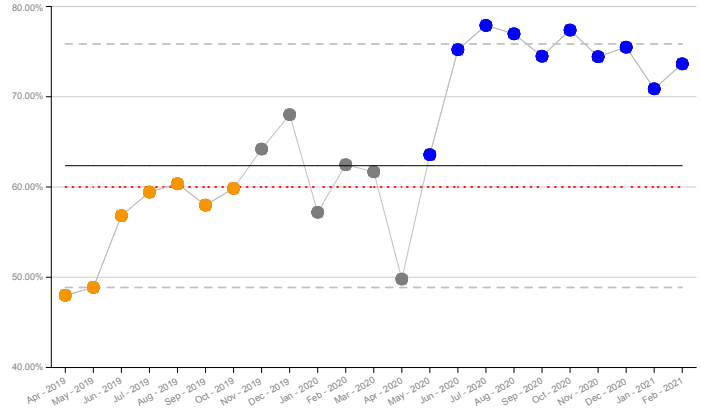
DURHAM AND DARLINGTON



FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



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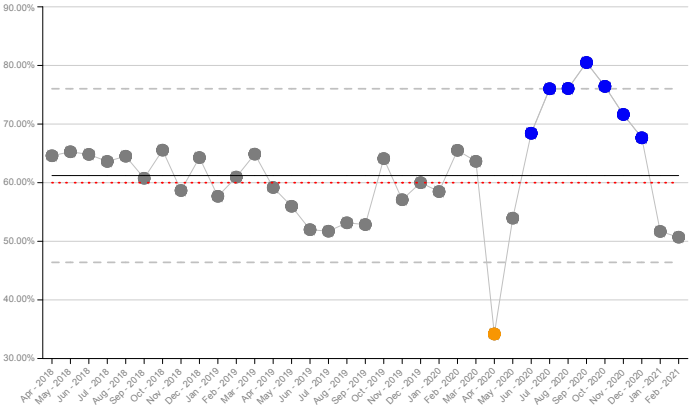
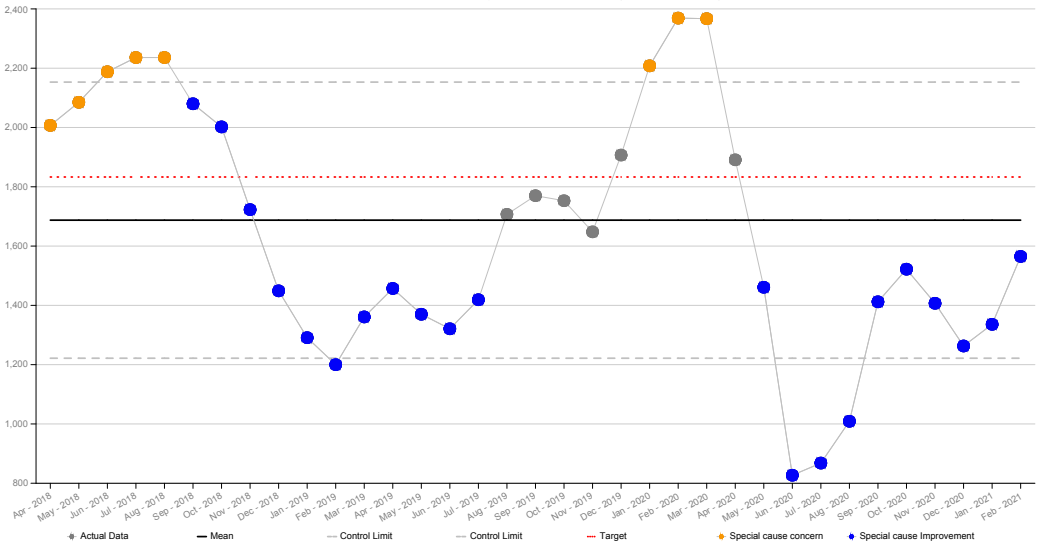
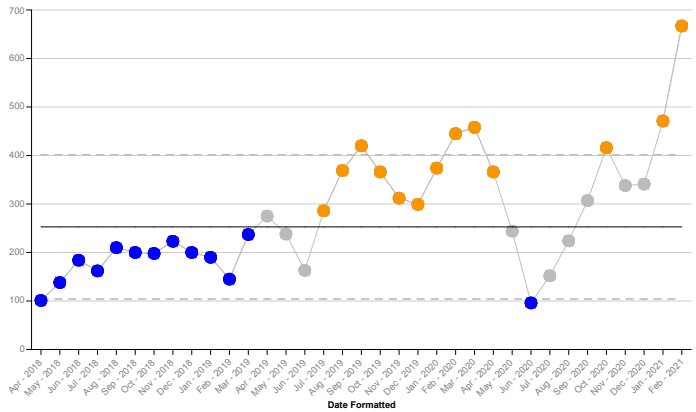


3) The total number of inappropriate OAP days over the reporting period (rolling 3 months) - TRUST

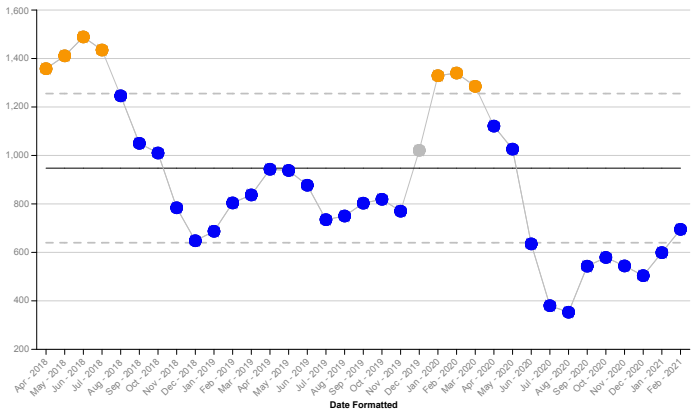


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L	?	1,687.40	2,153.08	1,221.72
DURHAM AND DARLINGTON	H		252.73	401.33	104.14
NORTH YORKSHIRE AND YORK	L		947.57	1,255.30	639.83
TEESSIDE	L		467.83	710.44	225.22

DURHAM AND DARLINGTON



NORTH YORKSHIRE AND YORK



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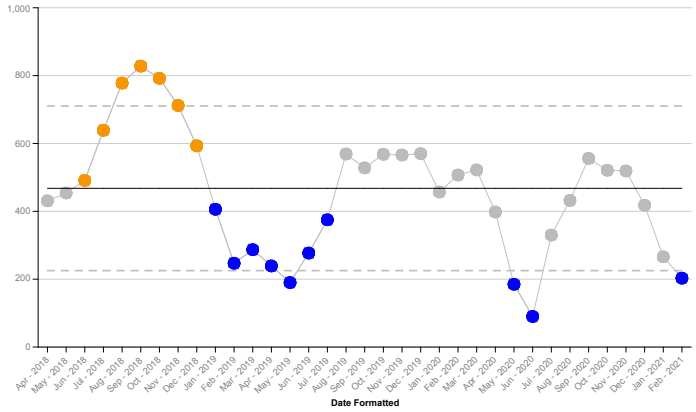
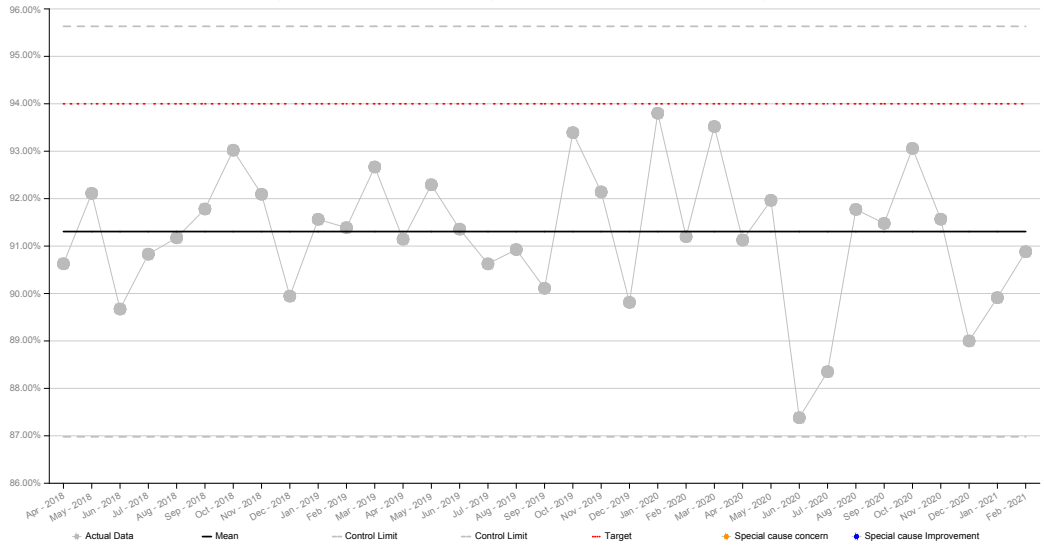
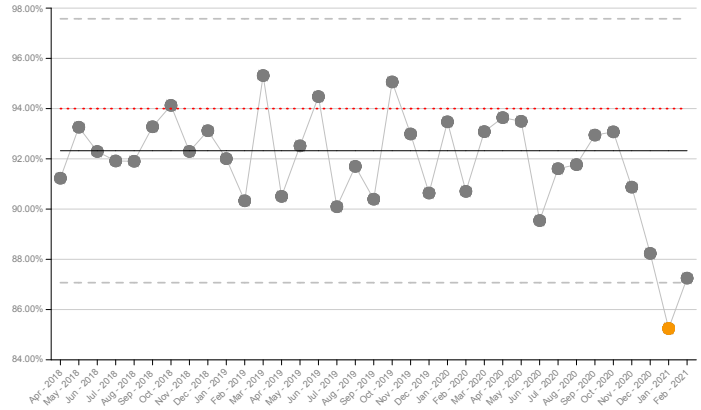


4) Percentage of patients surveyed reporting their overall experience as excellent or good - TRUST

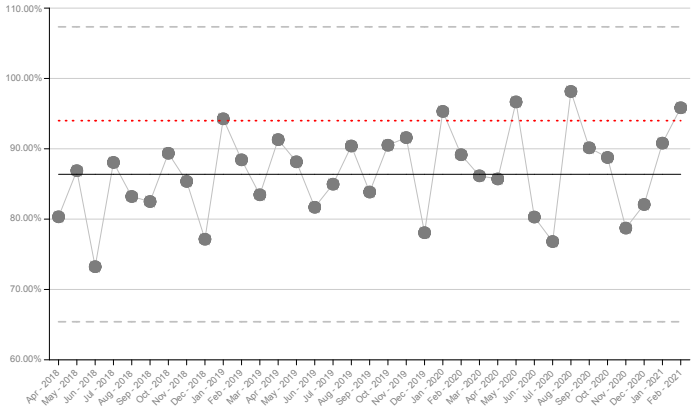


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			91.31%	95.63%	86.98%
DURHAM AND DARLINGTON			92.32%	97.58%	87.07%
FORENSIC SERVICES			86.37%	107.34%	65.41%
NORTH YORKSHIRE AND YORK			89.74%	98.34%	81.14%
TEESSIDE			92.91%	96.99%	88.83%

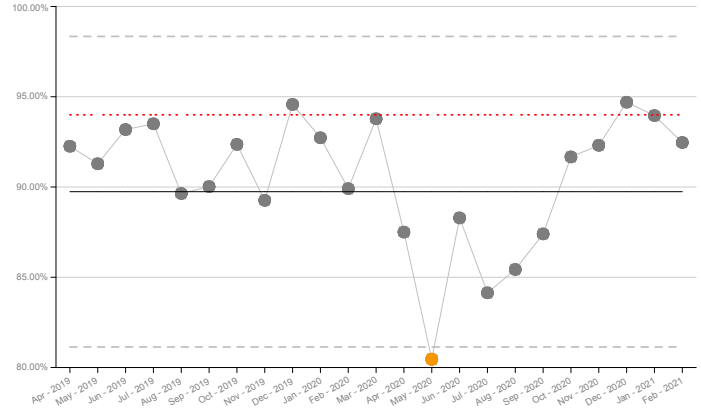
DURHAM AND DARLINGTON



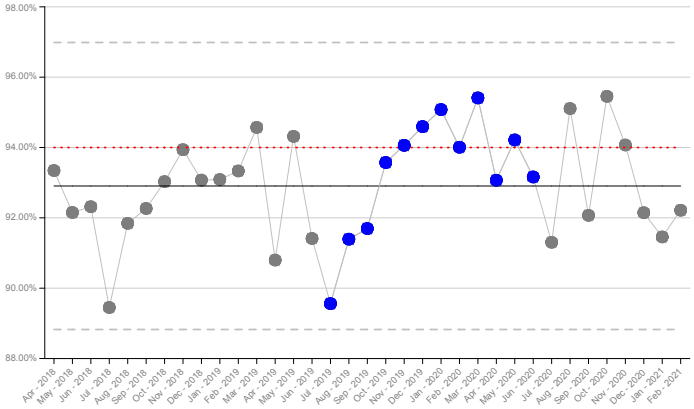
FORENSIC SERVICES



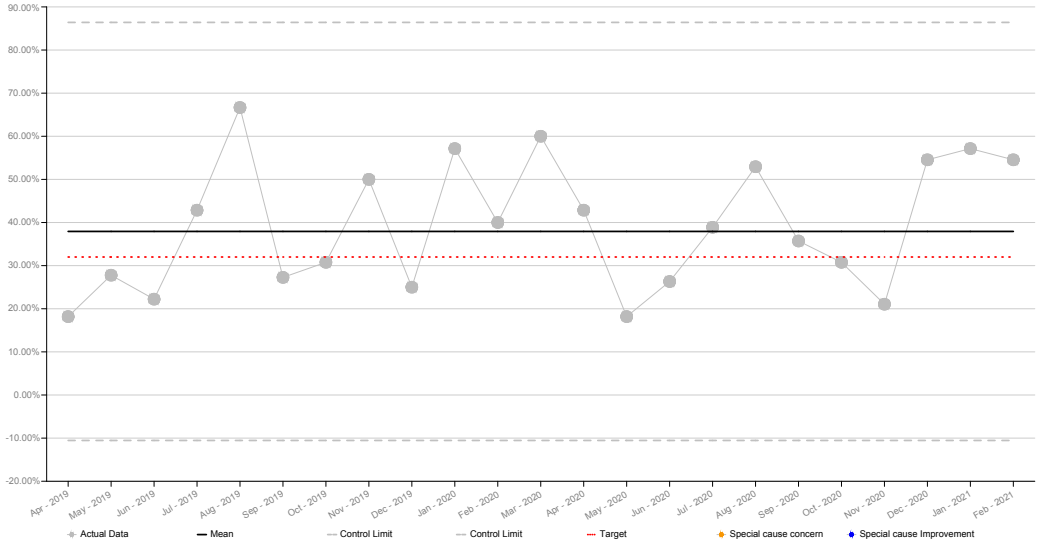
NORTH YORKSHIRE AND YORK



TEESSIDE

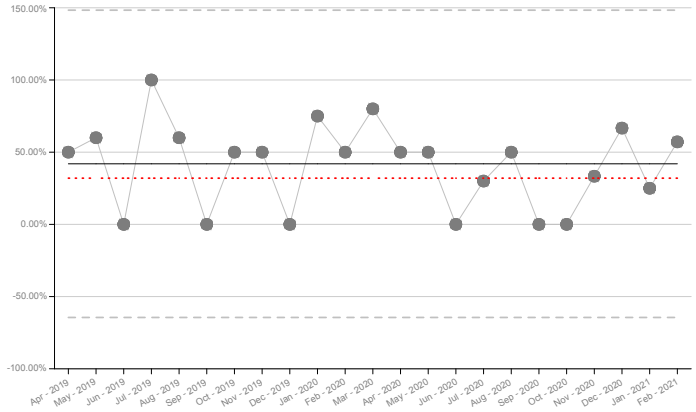


5) The percentage of Serious Incidents which are found to have a root cause or contributory finding - TRUST

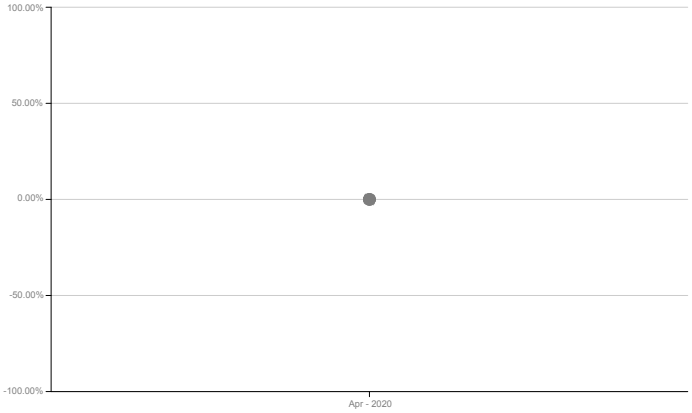


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			37.93%	86.41%	-10.54%
DURHAM AND DARLINGTON			41.94%	148.34%	-64.46%
NORTH YORKSHIRE AND YORK			44.79%	134.18%	-44.61%
TEESSIDE	H		29.62%	90.47%	-31.24%

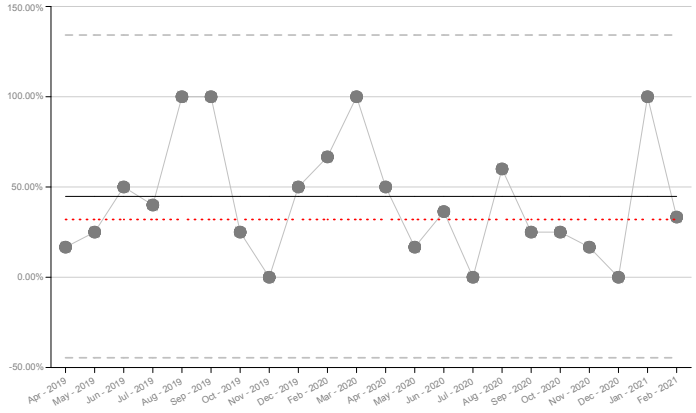
DURHAM AND DARLINGTON



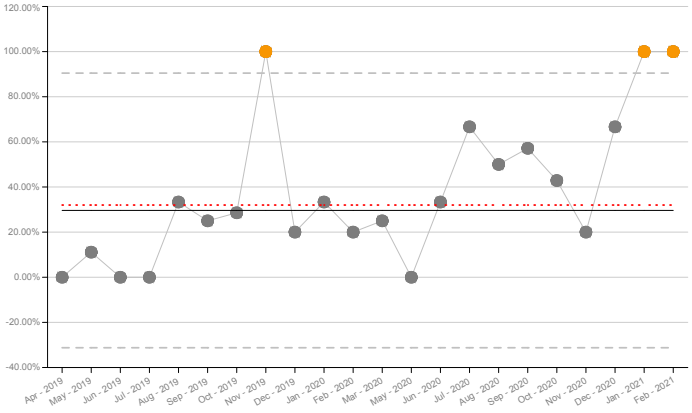
FORENSIC SERVICES



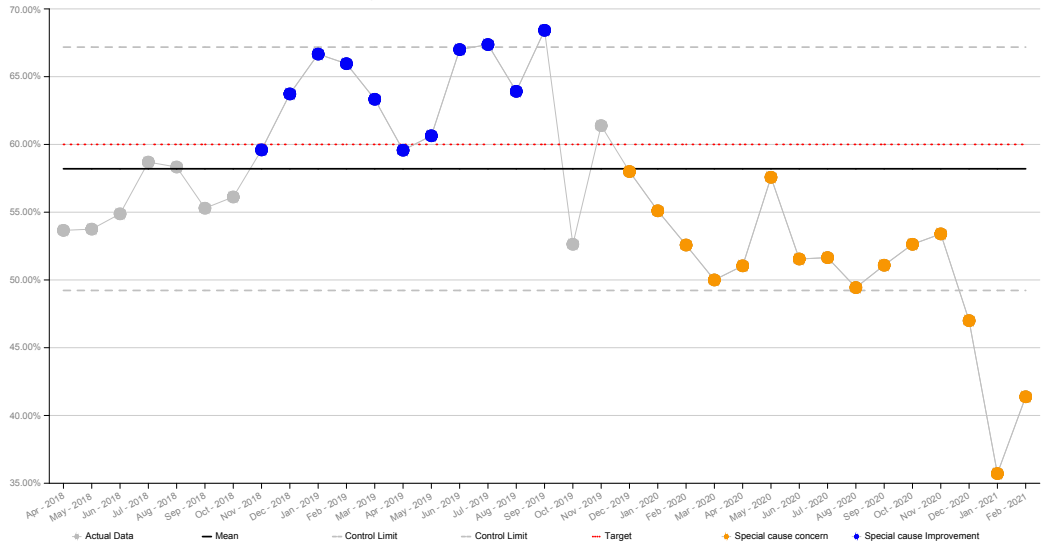
NORTH YORKSHIRE AND YORK



TEESSIDE

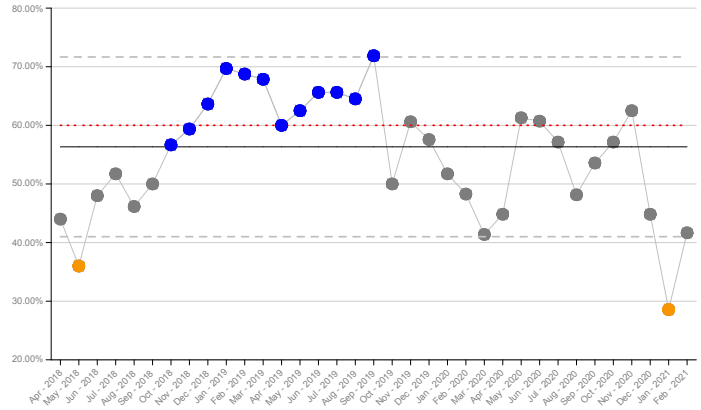


6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind - TRUST

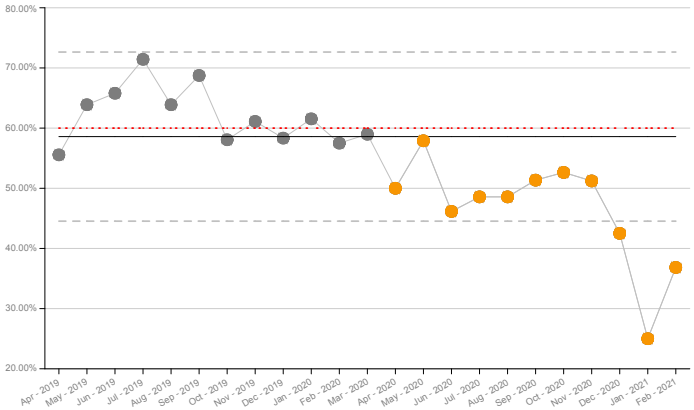


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L	?	58.20%	67.18%	49.22%
DURHAM AND DARLINGTON		?	56.33%	71.67%	41.00%
NORTH YORKSHIRE AND YORK	L	?	58.59%	72.64%	44.54%
TEESSIDE	L	?	58.69%	76.00%	41.37%

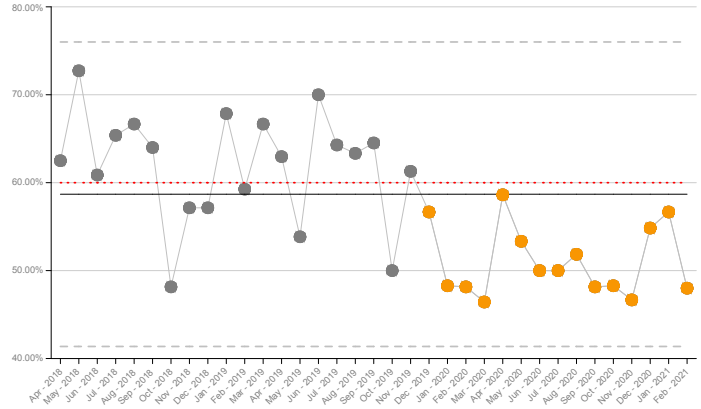
DURHAM AND DARLINGTON



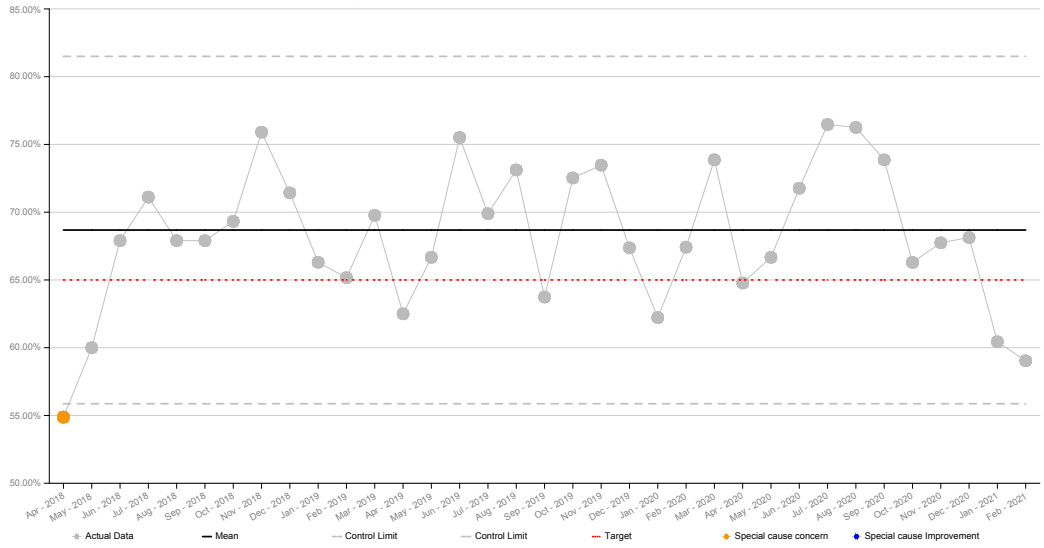
NORTH YORKSHIRE AND YORK



TEESSIDE

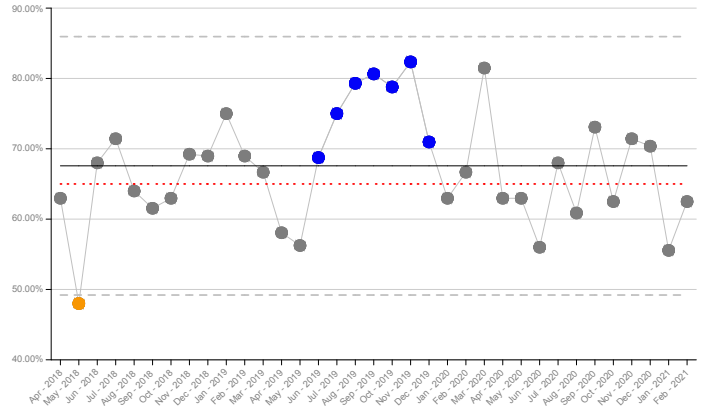


7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind - TRUST

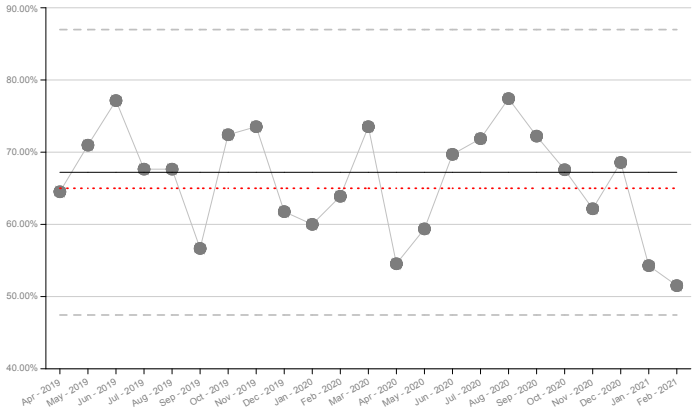


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			68.68%	81.50%	55.87%
DURHAM AND DARLINGTON			67.58%	85.95%	49.21%
NORTH YORKSHIRE AND YORK			67.21%	86.98%	47.45%
TEESSIDE			69.98%	90.67%	49.30%

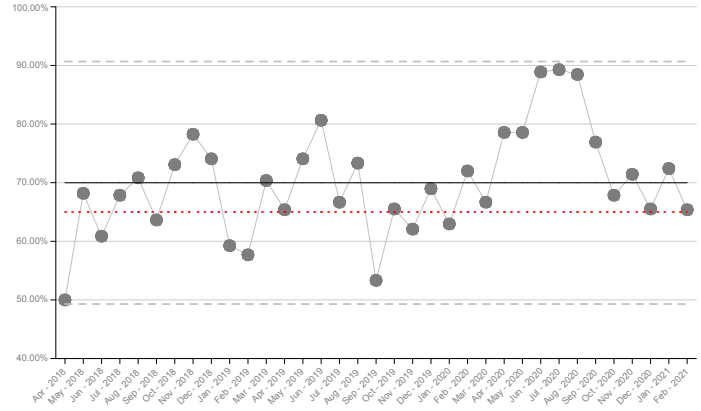
DURHAM AND DARLINGTON

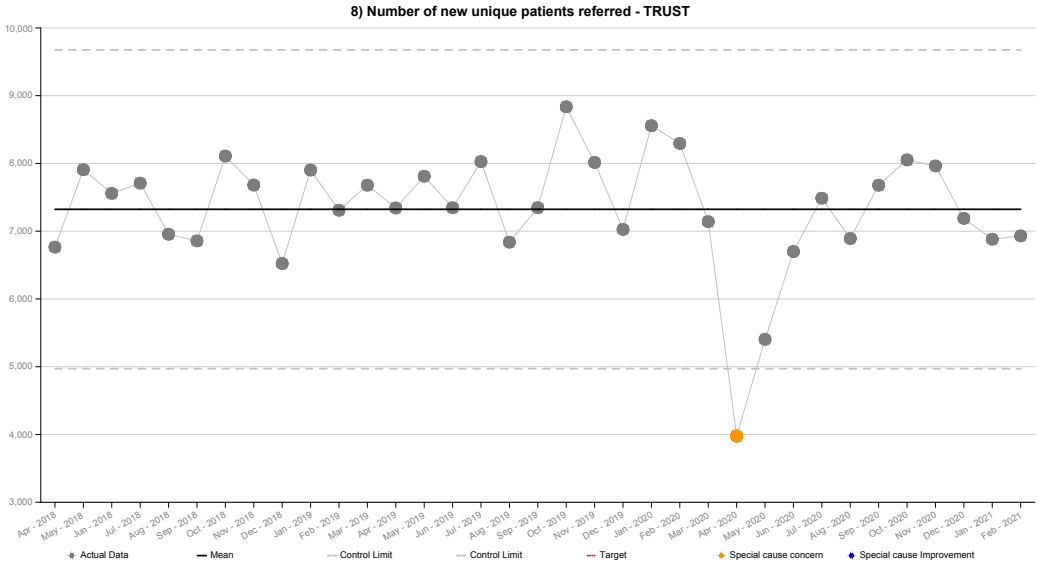


NORTH YORKSHIRE AND YORK

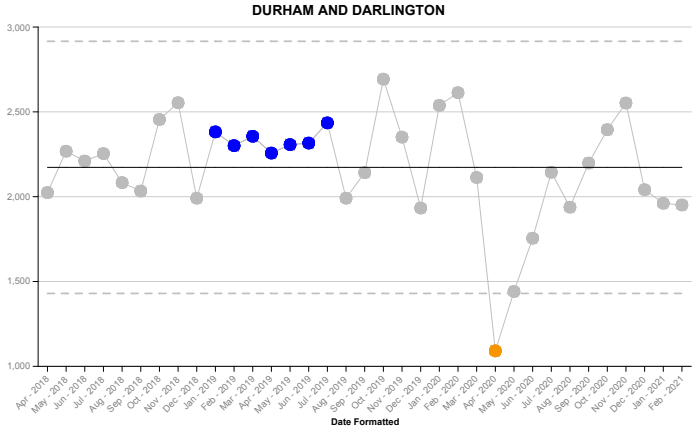


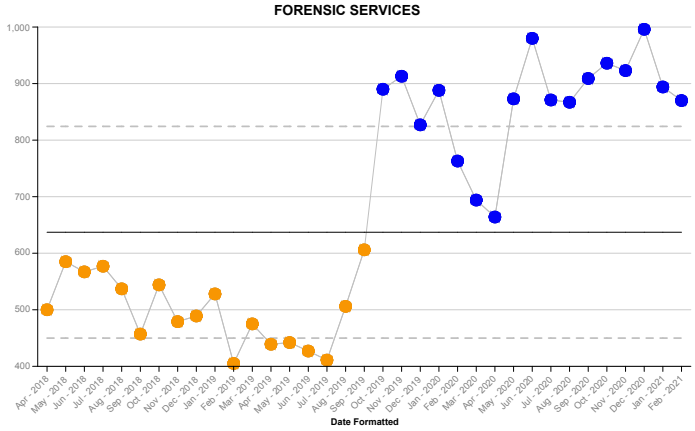
TEESSIDE

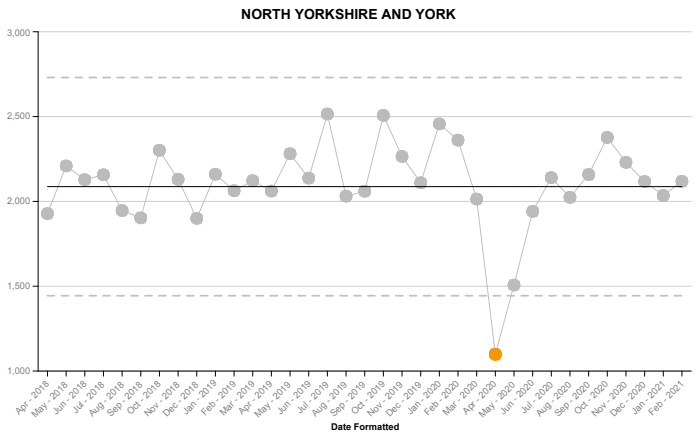


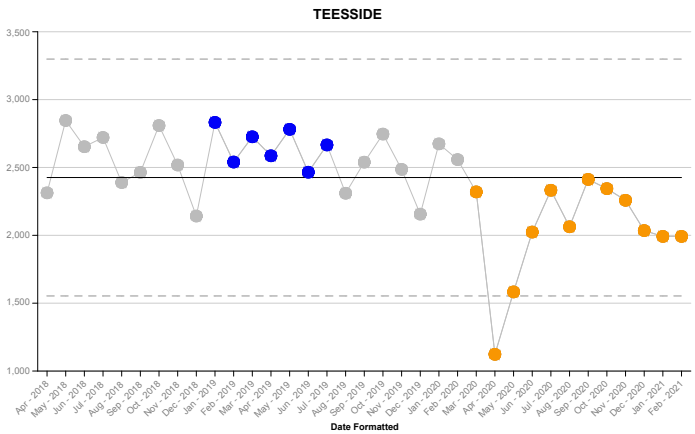


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			7,323.03	9,675.21	4,970.86
DURHAM AND DARLINGTON			2,172.80	2,915.95	1,429.65
FORENSIC SERVICES	H		637.10	824.31	449.89
NORTH YORKSHIRE AND YORK			2,087.13	2,730.30	1,443.96
TEESSIDE	L		2,425.93	3,298.41	1,553.45

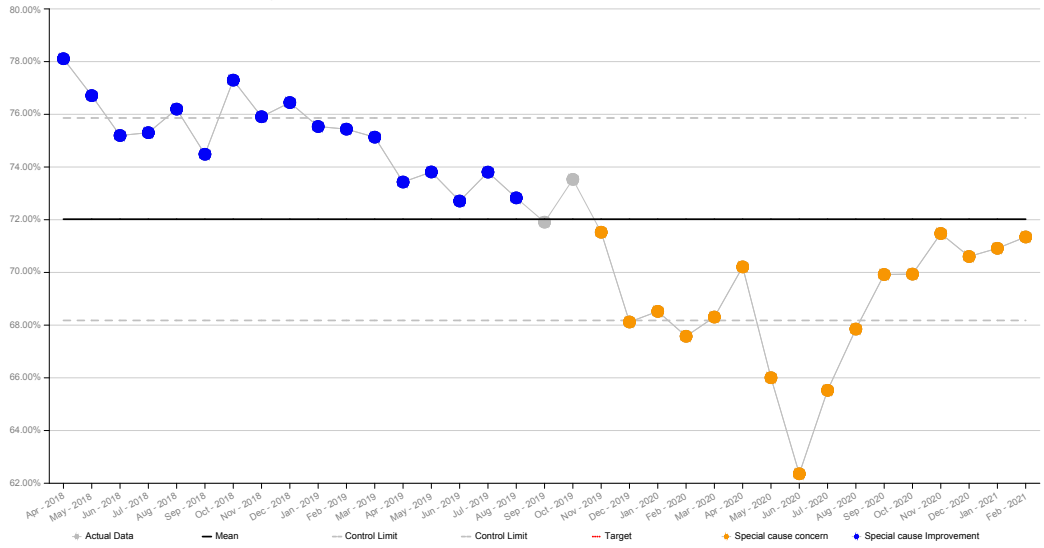






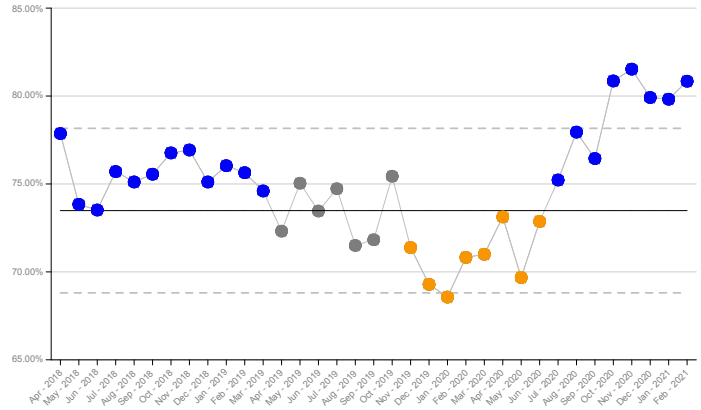


9) The percentage of new unique patients referred with an assessment completed (2 months behind) - TRUST

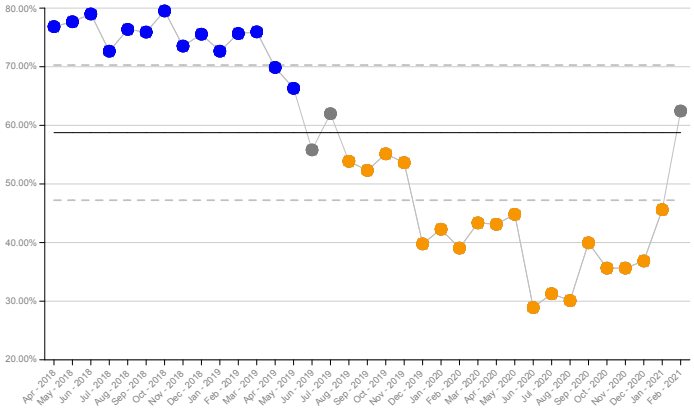


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L		72.02%	75.86%	68.18%
DURHAM AND DARLINGTON	H		73.48%	78.16%	68.81%
FORENSIC SERVICES			58.75%	70.28%	47.23%
NORTH YORKSHIRE AND YORK	L		72.63%	76.94%	68.31%
TEESSIDE			74.74%	79.53%	69.94%

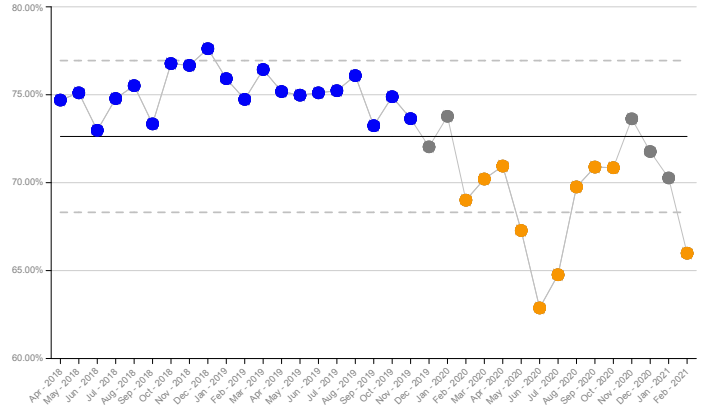
DURHAM AND DARLINGTON



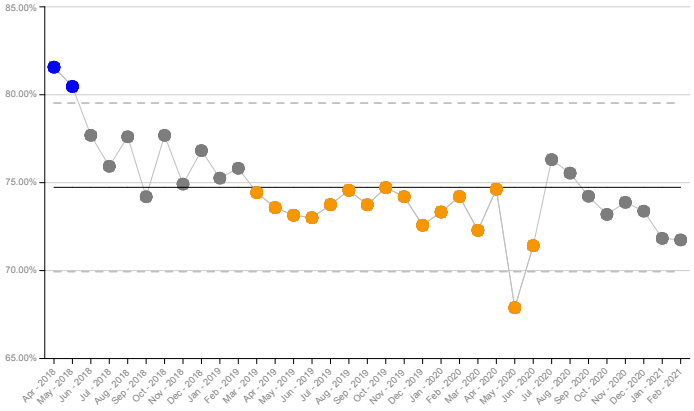
FORENSIC SERVICES



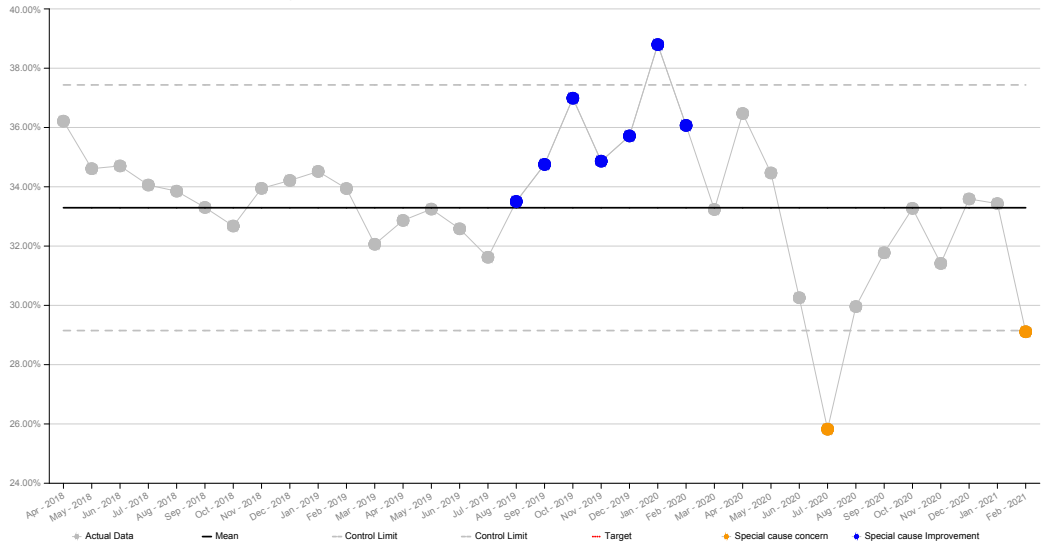
NORTH YORKSHIRE AND YORK



TEESSIDE

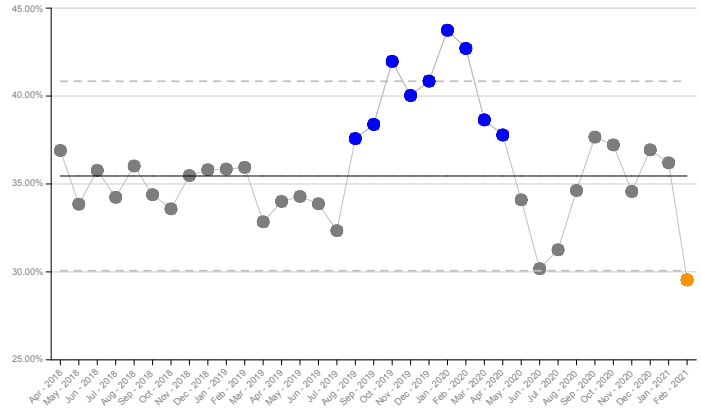


10) The percentage of new unique patients referred and taken on for treatment (3 months behind) - TRUST

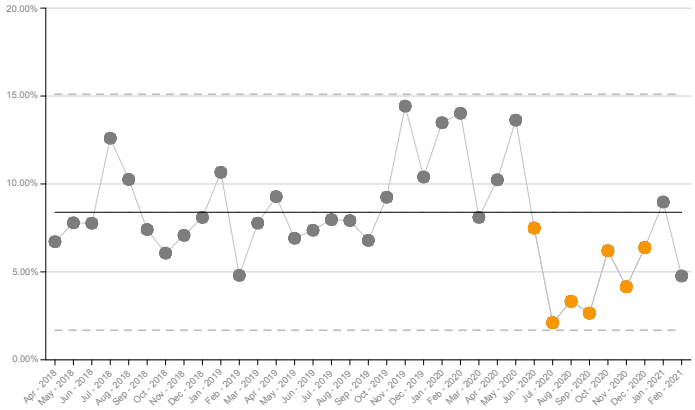


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L		33.29%	37.44%	29.15%
DURHAM AND DARLINGTON	L		35.45%	40.84%	30.07%
FORENSIC SERVICES			8.39%	15.10%	1.68%
NORTH YORKSHIRE AND YORK	H		40.13%	45.39%	34.88%
TEESSIDE	L		31.79%	36.04%	27.54%

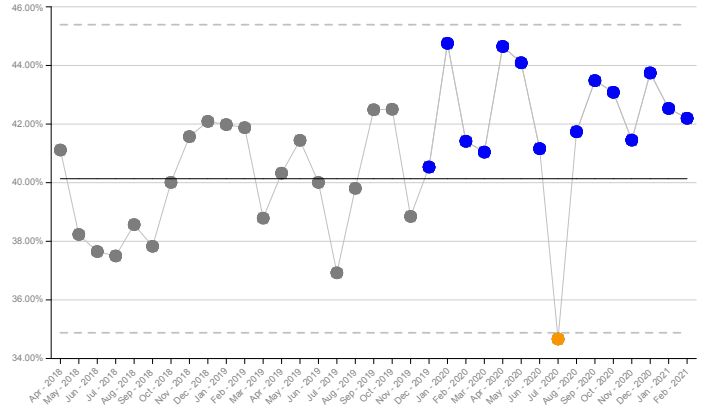
DURHAM AND DARLINGTON



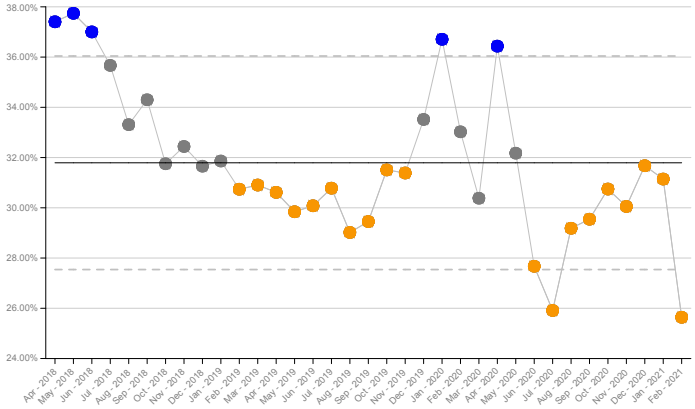
FORENSIC SERVICES



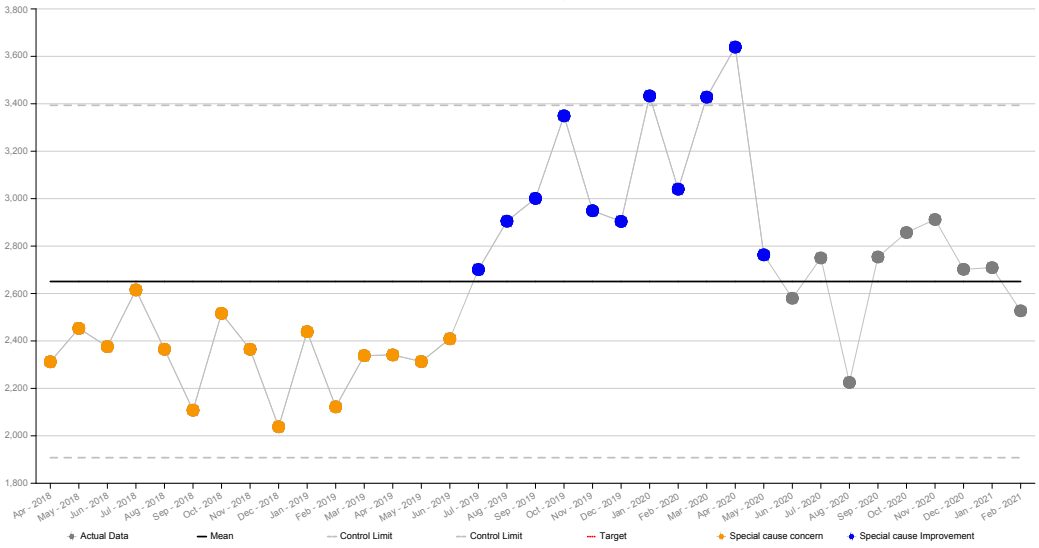
NORTH YORKSHIRE AND YORK



TEESSIDE

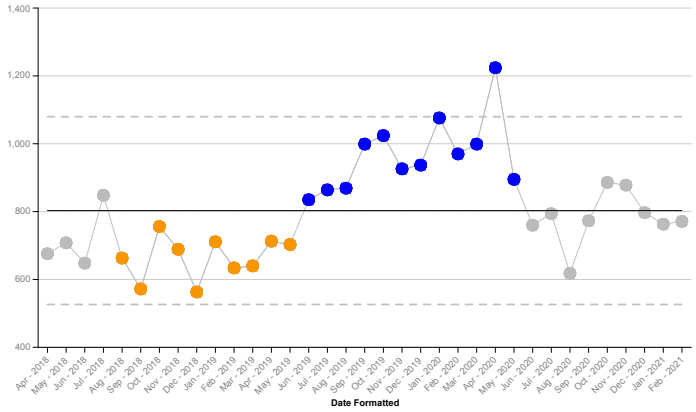


11) Number of unique patients discharged (treated only) - TRUST

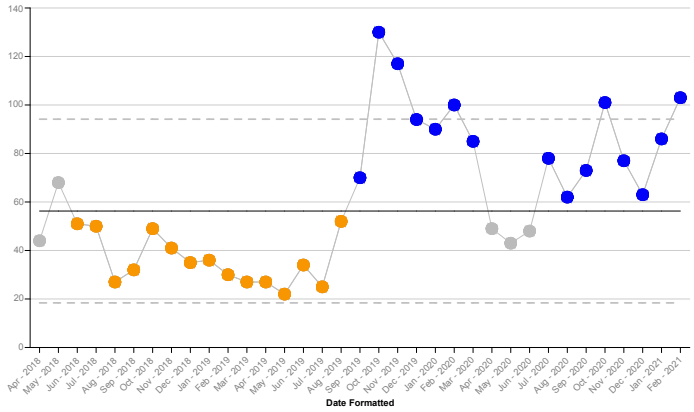


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			2,650.67	3,393.54	1,907.79
DURHAM AND DARLINGTON			802.97	1,079.70	526.23
FORENSIC SERVICES	H		56.27	94.15	18.38
NORTH YORKSHIRE AND YORK			908.80	1,171.04	646.56
TEESSIDE			882.63	1,171.56	593.70

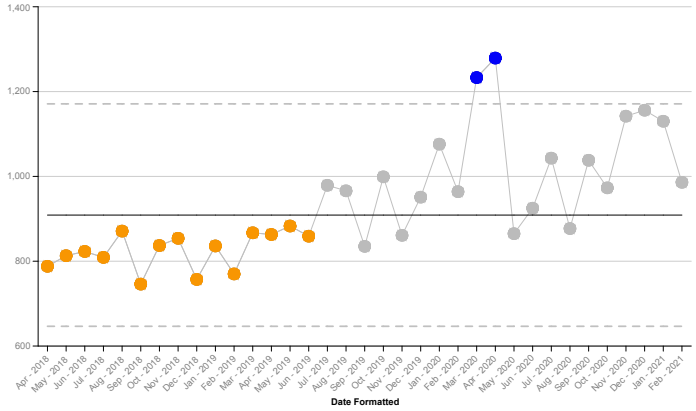
DURHAM AND DARLINGTON



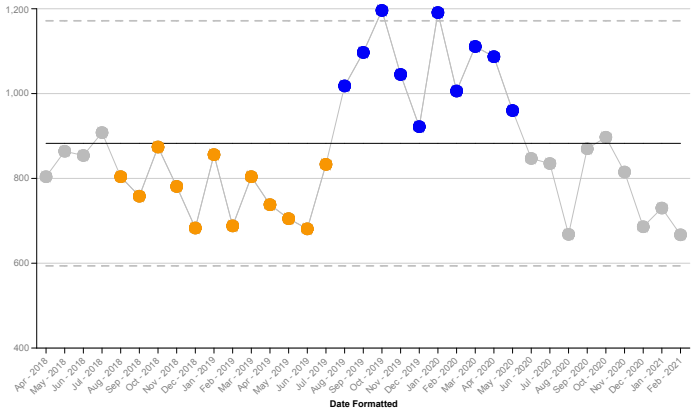
FORENSIC SERVICES



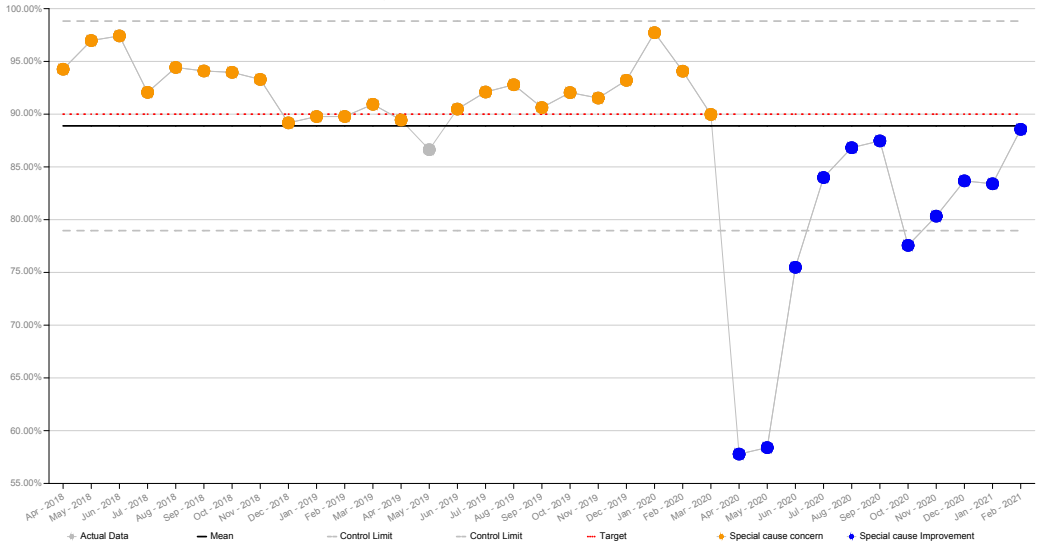
NORTH YORKSHIRE AND YORK



TEESSIDE

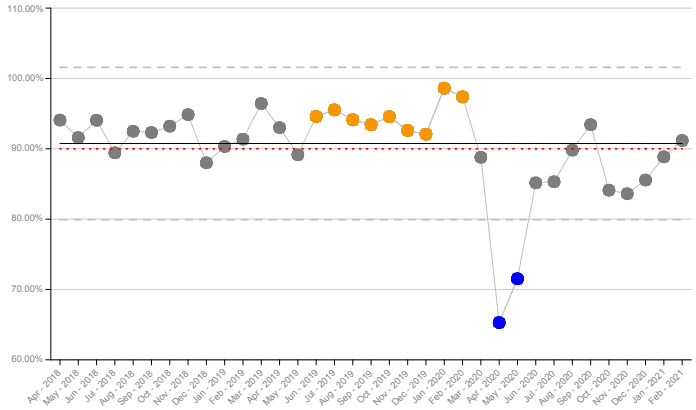


12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards) - TRUST

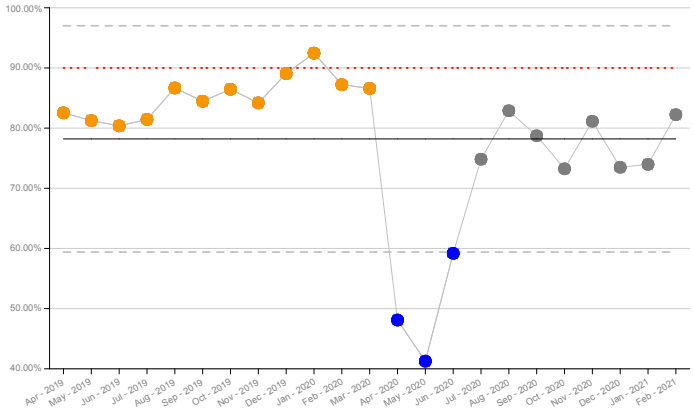


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L	?	88.89%	98.82%	78.96%
DURHAM AND DARLINGTON		?	90.75%	101.58%	79.92%
NORTH YORKSHIRE AND YORK		?	78.21%	97.01%	59.40%
TEESSIDE	L	?	95.52%	108.70%	82.34%

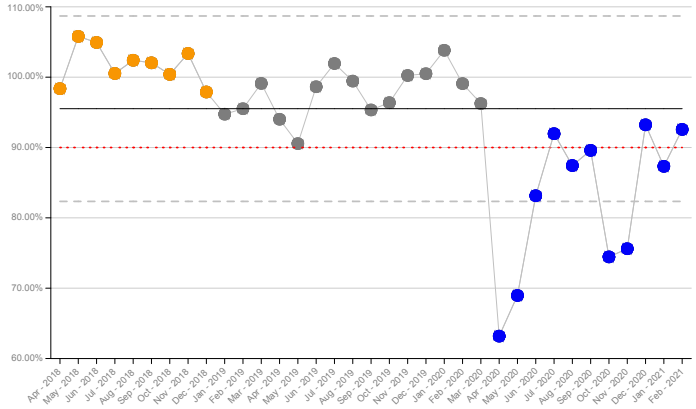
DURHAM AND DARLINGTON



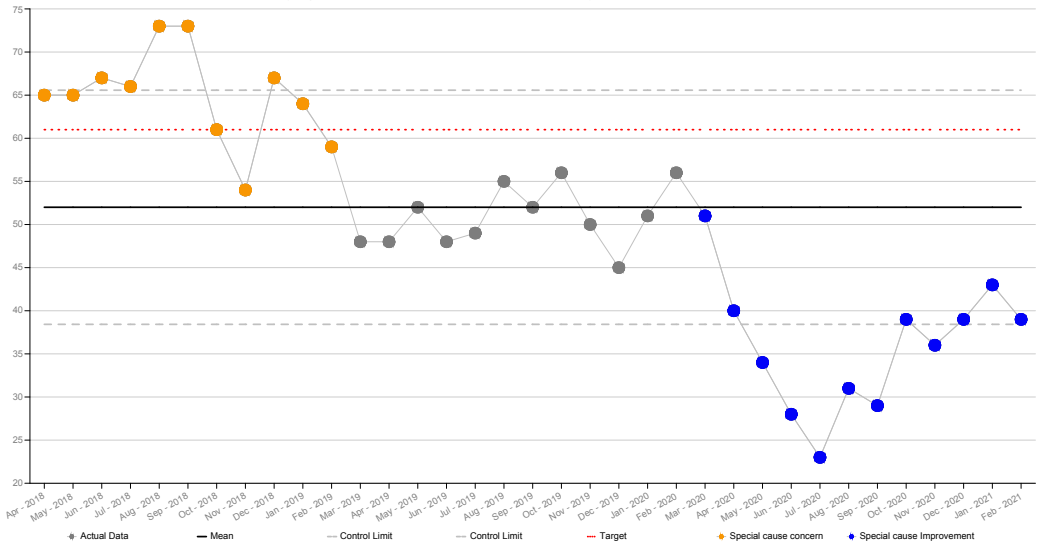
NORTH YORKSHIRE AND YORK



TEESSIDE

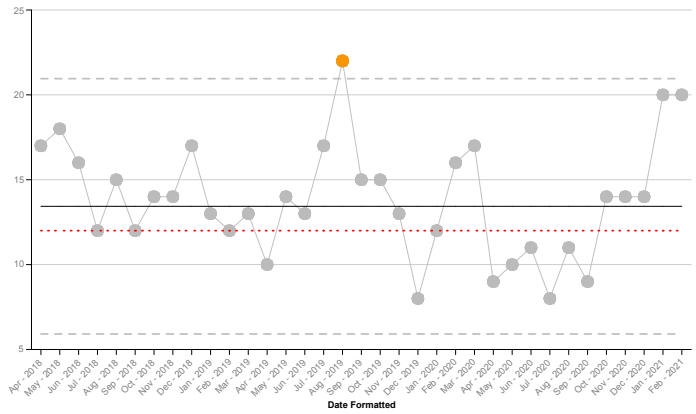


13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot - TRUST

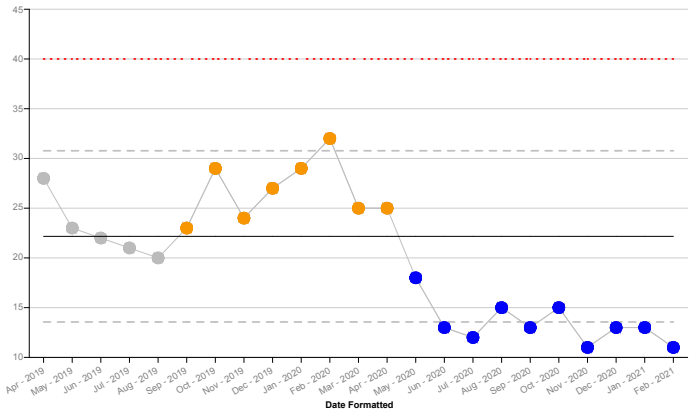


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L	?	52.00	65.58	38.42
DURHAM AND DARLINGTON		?	13.43	20.95	5.91
NORTH YORKSHIRE AND YORK	L	P	22.17	30.77	13.56
TEESSIDE		?	9.93	15.71	4.15

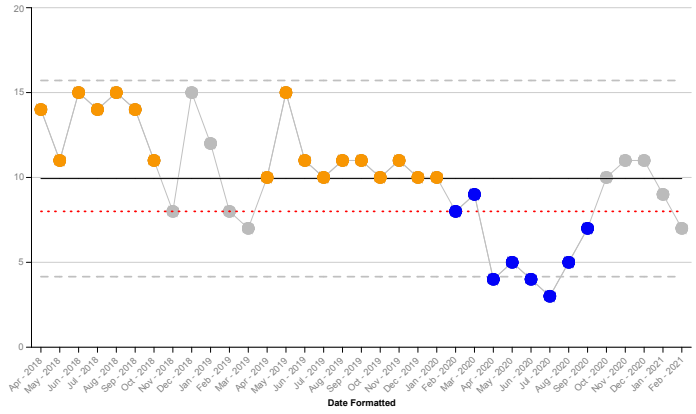
DURHAM AND DARLINGTON



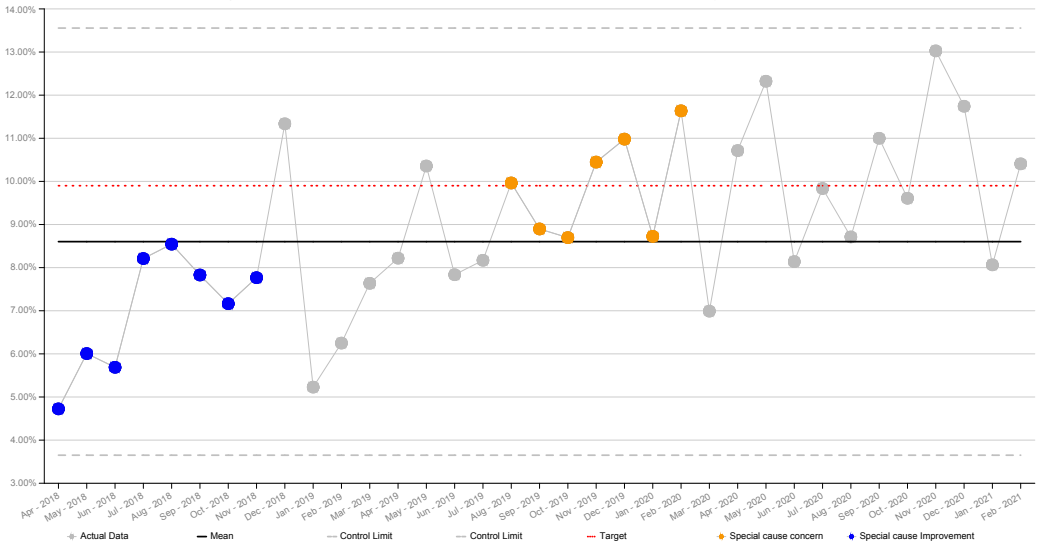
NORTH YORKSHIRE AND YORK



TEESSIDE

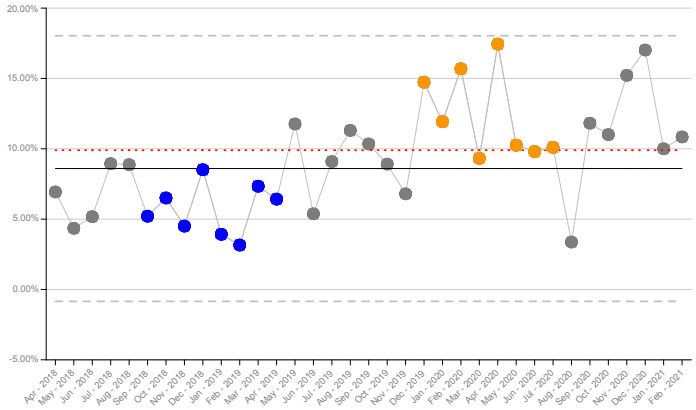


14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - TRUST

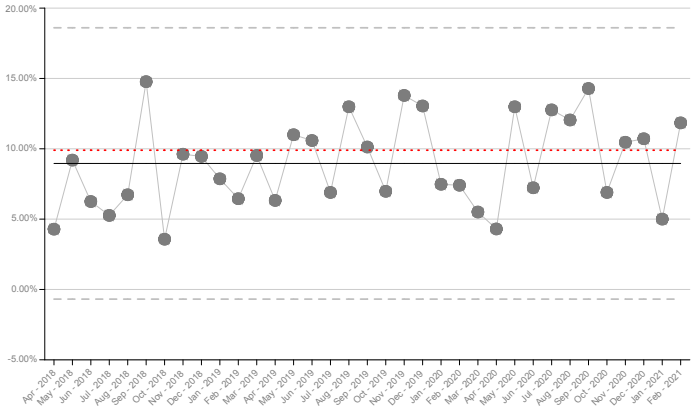


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			8.60%	13.56%	3.65%
DURHAM AND DARLINGTON			8.60%	18.04%	-0.85%
NORTH YORKSHIRE AND YORK			8.96%	18.60%	-0.69%
TEESSIDE			8.38%	19.57%	-2.82%

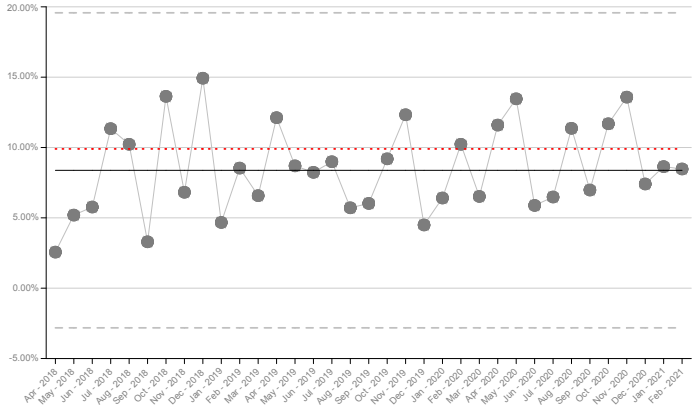
DURHAM AND DARLINGTON



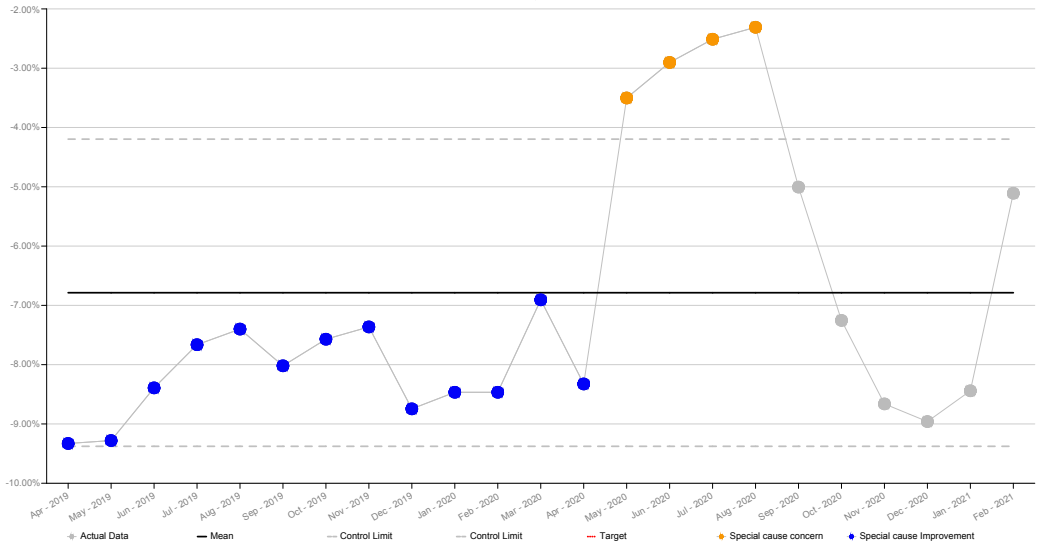
NORTH YORKSHIRE AND YORK



TEESSIDE

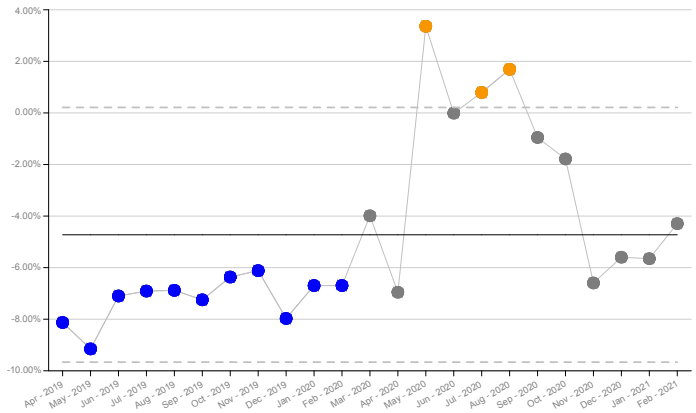


15) Finance Vacancy Rate - TRUST

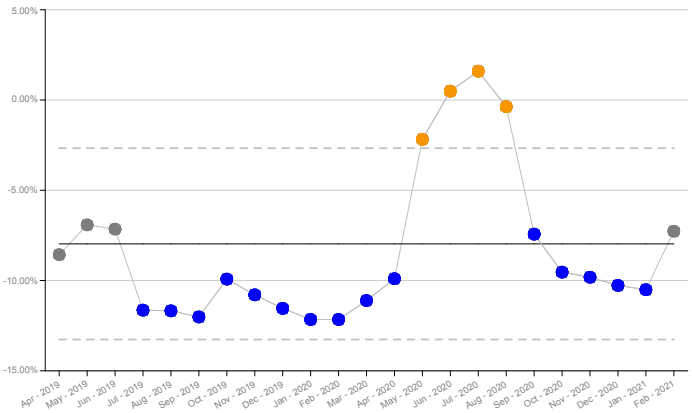


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			-6.79%	-4.20%	-9.38%
DURHAM AND DARLINGTON			-4.73%	0.21%	-9.66%
FORENSIC SERVICES			-7.97%	-2.67%	-13.27%
NORTH YORKSHIRE AND YORK			-6.62%	-3.58%	-9.67%
TEESSIDE			-6.09%	-2.94%	-9.24%

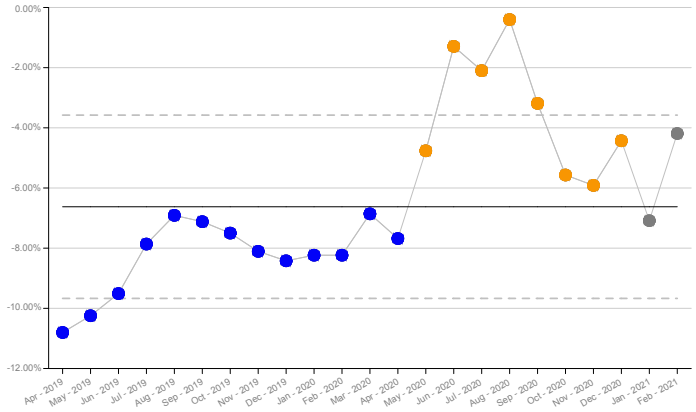
DURHAM AND DARLINGTON



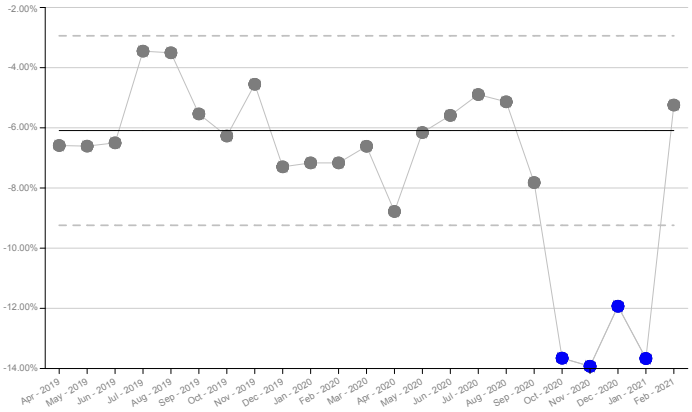
FORENSIC SERVICES



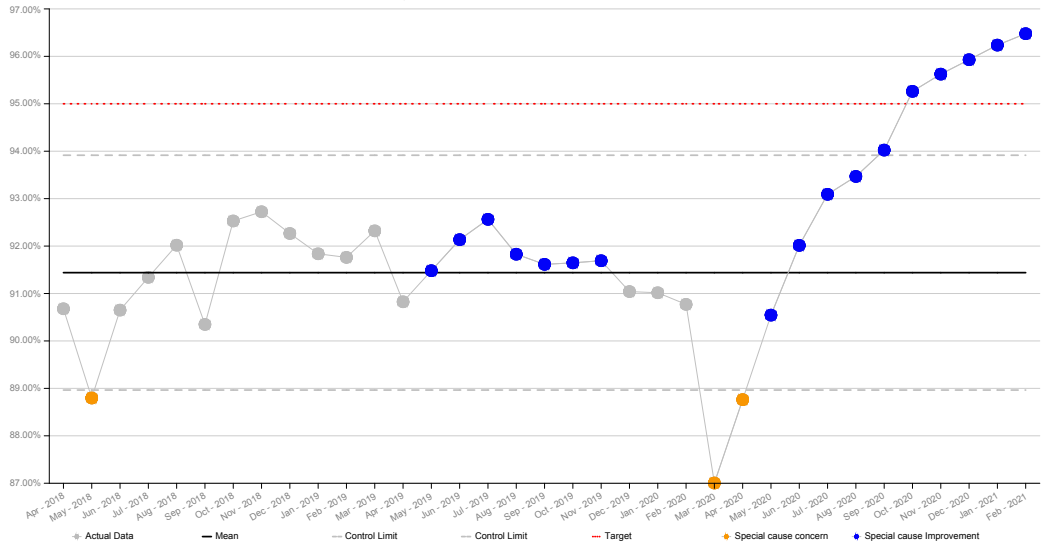
NORTH YORKSHIRE AND YORK



TEESSIDE

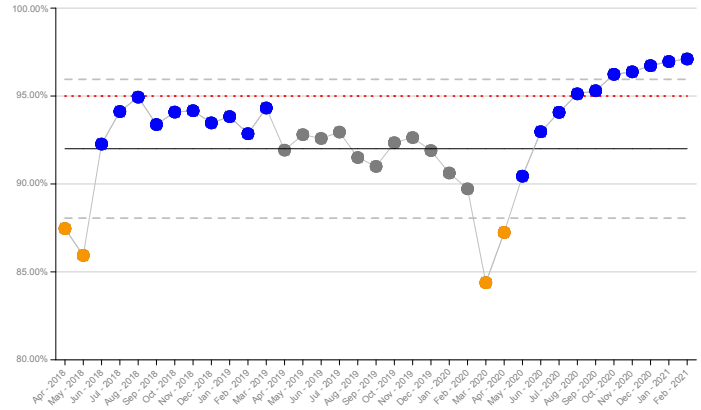


16) Percentage of staff in post with a current appraisal - TRUST

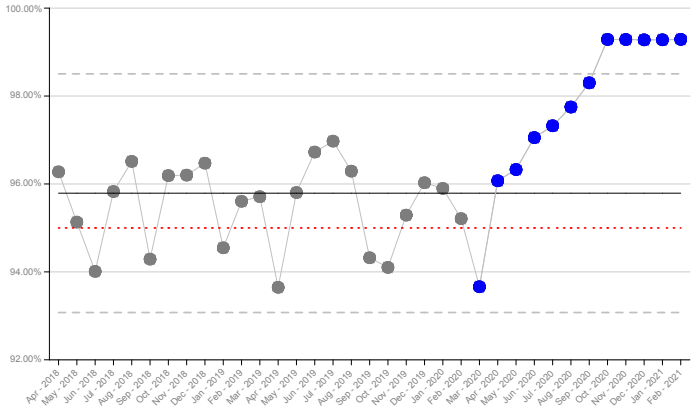


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	H	F	91.44%	93.92%	88.96%
DURHAM AND DARLINGTON	H	?	92.00%	95.95%	88.06%
FORENSIC SERVICES	H	?	95.79%	98.50%	93.08%
NORTH YORKSHIRE AND YORK	H	F	89.65%	92.84%	86.47%
TEESSIDE	H	?	93.23%	95.96%	90.49%

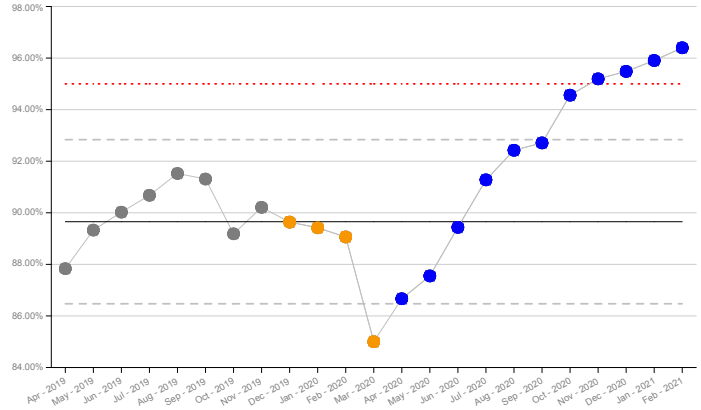
DURHAM AND DARLINGTON



FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



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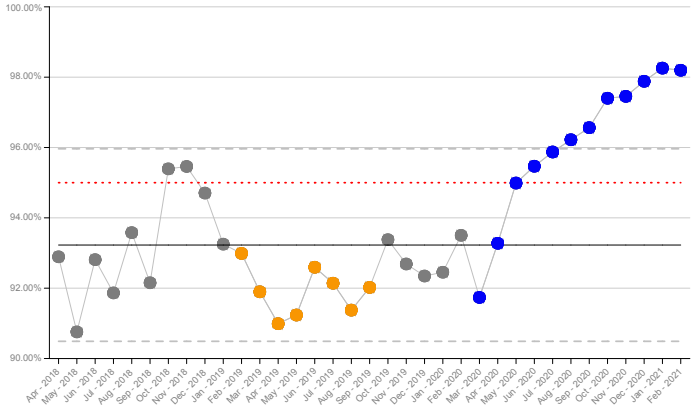
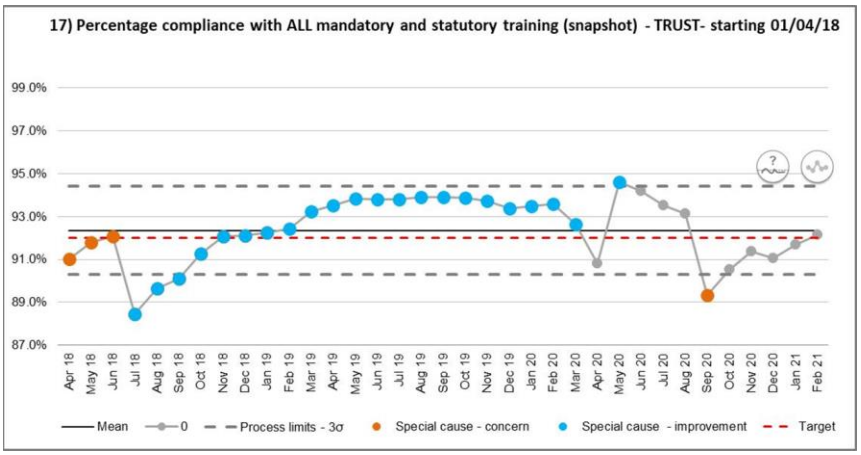
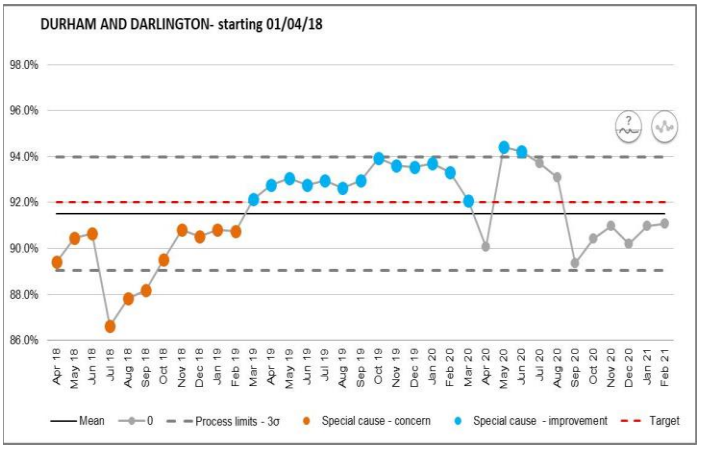


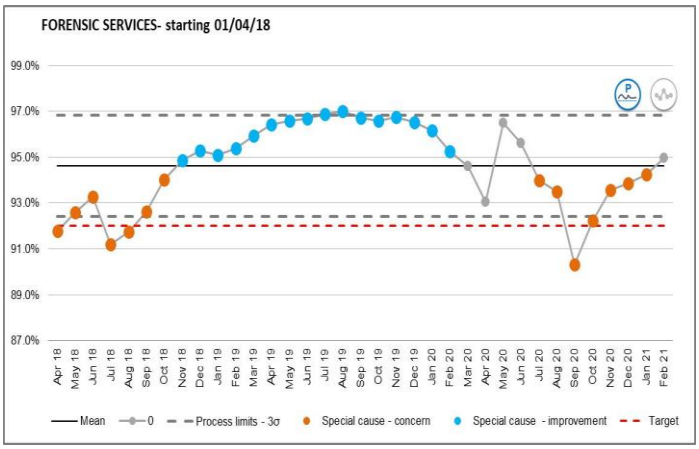
TRUST Indicator Details

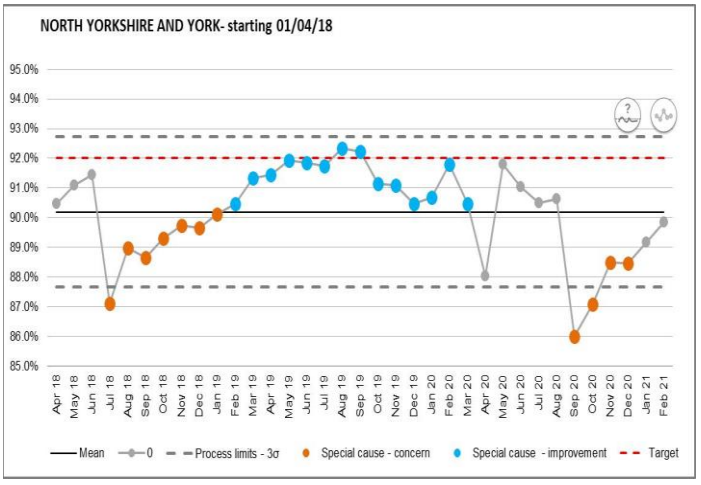
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

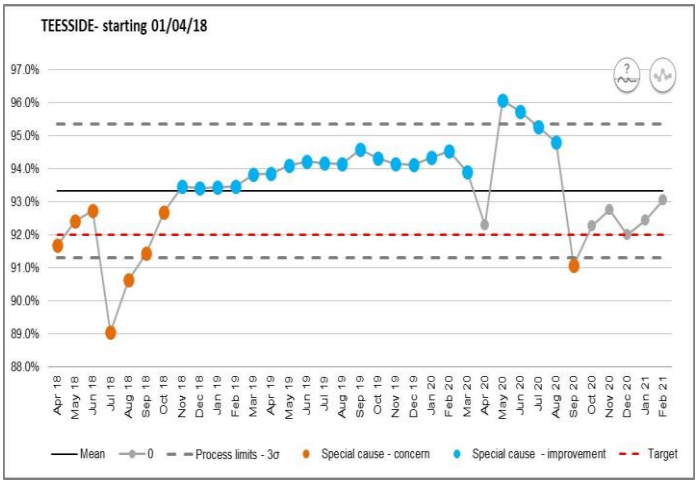


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Low er Control Limit
TRUST		?	92.30%	94.00%	90.00%
DURHAM AND DARLINGTON		?	91.50%	94.00%	89.00%
FORENSIC SERVICES		P	94.60%	97.00%	92.00%
NORTH YORKSHIRE AND YORK		?	90.20%	93.00%	88.00%
TEESSIDE		?	93.30%	95.00%	91.00%

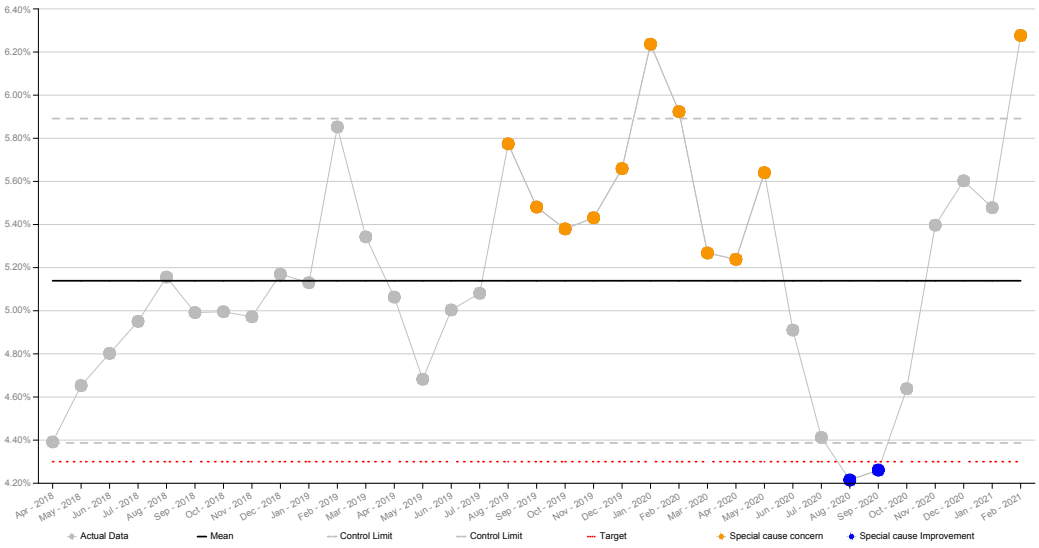






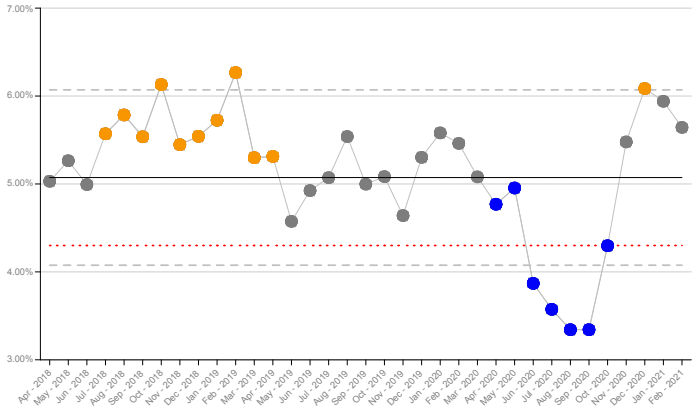


18) Percentage Sickness Absence Rate (month behind) - TRUST

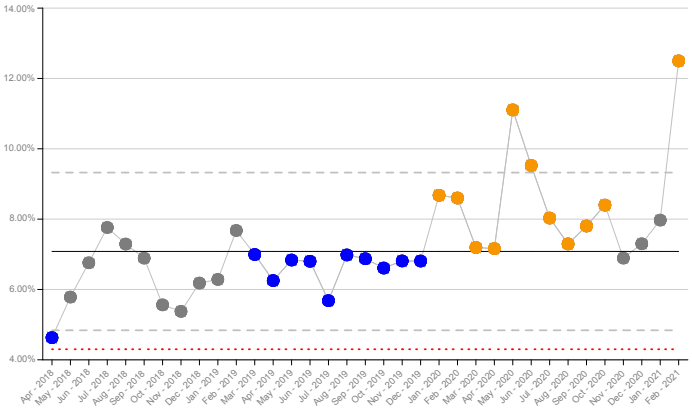


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	H	F	5.14%	5.89%	4.39%
DURHAM AND DARLINGTON		?	5.07%	6.07%	4.08%
FORENSIC SERVICES	H	F	7.08%	9.32%	4.84%
NORTH YORKSHIRE AND YORK	H	?	4.23%	5.13%	3.32%
TEESSIDE		F	5.49%	6.58%	4.40%

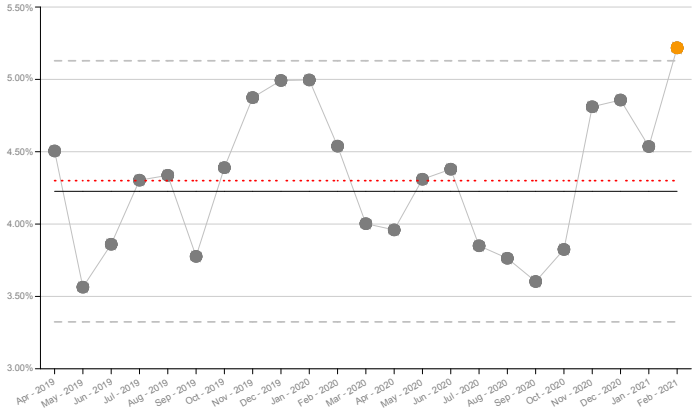
DURHAM AND DARLINGTON



FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



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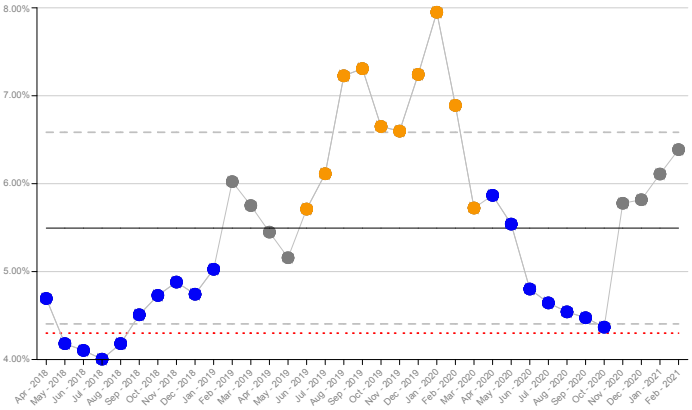


Tees, Esk and Wear Valleys NHS Foundation Trust

SPC Icon Definitions

Icon	Description
	1. Variation indicates inconsistently hitting, passing or falling short of the target
	2. Variation indicates consistently (F)alling short of the target
	3. Variation indicates consistently (P)assing the target
	4. Common cause - no significant change
	5. Special cause of concerning nature or higher pressure due to (H)igher values
	6. Special cause of concerning nature or higher pressure due to (L)ower values
	7. Special cause of improving nature or lower pressure due to (H)igher values
	8. Special cause of improving nature or lower pressure due to (L)ower values

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

TDB2 - Percentage of patients starting treatment within 6 weeks of an external referral – Teesside locality

TEWV is committed to ensuring that all patients referred into our services receive timely treatment, supporting patient safety, wellbeing and quality of care.

Analysis based on data ending February 2021

- Teesside are displaying common cause variation; however a 5th consecutive monthly deterioration is observed and the locality reports below both the mean and standard. Both the denominator (number of patients starting treatment) and numerator (number of patients starting treatment within 6 weeks of an external referral) show cause for concern, with the denominator reporting cause for concern for 11 consecutive months.
- Within CYPS cause for concern is displayed; a 5th consecutive month deterioration is observed and the service reports below both the mean and the standard. Both the denominator and numerator show cause for concern, with the numerator reporting cause for concern for 11 consecutive months. Further work is required to understand this.
- Within AMH cause for concern is displayed; a 3rd consecutive monthly deterioration is observed and the service reports below both the mean and standard. Both the denominator and numerator show cause for concern, with the denominator reporting cause for concern for 12 consecutive months and the numerator for 8. Further work is required to understand this.
- Within MHSOP common cause variation is displayed with performance just below the mean and standard; this is not an area of concern at this point.
- Within LD common cause variation is displayed with the latest data point below the mean but above the standard; therefore this is not an area of concern.

Conclusions

Cause for concern is identified for both CYPS and AMH, with consecutive deteriorations in both services being observed. Further detailed analysis is required in AMH and CYPS to better understand the underying reasons for this.

Actions we will take

- A detailed deep dive analysis is to be undertaken to identify any key areas of concern within AMH and CYPS. This will be supported by the Corporate Performance Team and an initial update will be provided in April 21 with the review being completed and findings fully reported to Board in May 21.
- This measure will continue to be monitored via routine monthly processes within MHSOP and LD, supported by Corporate Performance.

Recommendations

- To note the analysis that has taken place and the actions being taken in relation to this measure and agree to receive an initial update in April 21 and a final report in May 21.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

TDB03 – The total number of inappropriate OAP days over the reporting period (rolling 3 months) – <u>Durham and Darlington locality</u> *The Trust is committed to ensuring that all patients are treated in a location that helps them to retain contact with family, carers and friends, and to feel as familiar as possible with the local environment.*

Analysis based on data ending January 21

Durham and Darlington are displaying special cause concern, with the latest positon above the mean and the upper process limit.

Initial analysis has been undertaken at Specialty and Ward level (relating to the ward patients were admitted to).

- Within AMH services special cause concern is indicated with the position above both the mean and upper process limit. Initial analysis has identified that 97% (293) of AMH out of locality bed days were female patients in beds in North Yorkshire and York and Tees Locality. One of these patients had a length of stay of 92 days. During the same time period, Durham and Darlington wards accommodated 111 bed days from female patients from other localities (36 North Yorkshire and York and 75 Tees) . One individual patient had a length of stay of 62 days.
    - When there is a requirement to place patients out of the locality their complexity and vulnerability is considered to ensure they are placed in the most appropriate bed. AMH have seen an increase in the number of females requiring admission and due to the complexity of their needs their lengths of stay on the wards have been longer than usual and as a result there has been a need to admit patients to beds outside their local area .
    - In addition during February, an outbreak of COVID saw the closure of both the female and male wards at West Park Hospital to new admissions, as a result more patients were accommodated out of area during this time.
- Within MHSOP common cause variation is indicated with the position just above the mean. Initial analysis has identified that 77.38% (130) MHSOP out of locality bed days were organic patients from Durham and Darlington in beds in the Tees Locality. During the same time period Durham and Darlington organic wards accommodated 45 bed days from patients (2) from Tees locality. Of the remaining bed days 24 bed days were functional patients in beds in Tees locality and 14 bed days were patients in the assessment and treatment ward in North Yorkshire and York. During the same time Durham and Darlington functional wards accommodated 59 bed days with patients from other localities (5 Tees and 54 North Yorkshire and York)
- Further analysis is required to understand the position in both specialities in more detail and the factors that have impacted. This will include triangulation with other key measures such as bed occupancy and length of stay.

Conclusions

The current position within the locality has been mostly impacted by inappropriate OAP days in AMH services.

Further detailed analysis is required to better understand the areas of concern in AMH and MHSOP.

Actions we will take

More detailed analysis will be undertaken to identify the key areas of concern and any possible actions that could be taken to improve the position within AMH and MHSOP. This work will be supported by the Corporate Performance Team, working in collaboration with the operational services and this will be shared next month.

Recommendations

To note the analysis that has taken place, the actions we will take in relation to this measure and to agree to receive an update in April 21.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

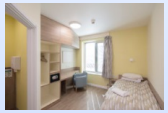
TD 06) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind – Durham & Darlington Locality - *TEWV is committed to making a difference to people's lives and supports the use of Routine Outcome Measures, which add to the quality of the work we do and are meaningful to both service users and clinical staff. Used effectively, outcomes can significantly enhance the therapeutic alliance between service users and clinicians and lead to improvements for both.*

Analysis based on data ending January 21

- Durham and Darlington Locality is indicating special cause for concern with the latest data point below the lower process limit and that the standard will will be met and sometimes missed due to random variation.
- AMH services demonstrate special cause for concern with latest data point below the lower process limit. The numerator (the number of in scope teams with patients whose patients spells have ended and achieved the agreed improvement in their HONOS score) shows cause for concern with the latest data point below the lower process limit. Further investigation is required to understand the issues within the speciality.
- Mental Health Services for Older People (MHSOP) demonstrate common cause variation with the latest data point below the lower process limit. The numerator shows common cause variation with the latest data point just above the lower process limit. Further investigation is required to understand the issues within the speciality.

Conclusions

- The current position within the locality is mostly impacted by performance of AMH against this measure. However MHSOP are now within the lower process limit.
- Further detailed analysis is required to better understand the areas of concern at speciality and team level and the possible actions that could be taken to improve the position.



Actions we will take

- A more detailed analysis is to be undertaken by the Corporate Performance Team, alongside discussions with the locality, to identify key areas of concern within AMH and MHSOP community teams, including those teams with a low common cause variation. This will be completed by the end of March 21.
- A trust wide meeting between the Corporate Performance Team, Service Development Managers and Clinical Leads will take place during March to outline the work completed around this measure to date and agree on the most appropriate way to take this forward in an integrated way in order to improve performance in this area.

Recommendation

To note the analysis that has taken place, the actions we will take in relation to this measure and to agree to receive an update in April 21.

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) – Tees Locality

The Trust is committed to ensuring that all patients referred into our services receive timely treatment, supporting patient safety, wellbeing and quality of care.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Conclusions to date

- CYP are moving to a new service model which means a more integrated approach with partners and involves supporting the signposting of referrals to enable the right level of treatment to meet individual needs. This means a proportion of CYP will not be taken on for treatment. Since the start of the pandemic, referrals to the CAMHS Crisis Service have reduced and for those referrals received, a greater proportion are for telephone advice or signposting to partners to provide a more appropriate level of care. As a result there has been a reduction in the number of referrals taken on for treatment; however all receive the level of intervention required.
- MHSOP services also have a service model which supports signposting to alternative more appropriate services however there is some variation in performance across the teams.
- LD Services receive a number of referrals which are either inappropriate or are for dementia screening and do not require treatment. Inaccurate recording of rejected referrals was identified within one team, which has now been addressed.
- This measure may not be fit for purpose as it includes all patients that have been referred and not necessarily assessed and accepted for service.

Update on actions

- At the time of initial escalation, the teams showing cause for concern within MHSOP were the Community Teams for Redcar & Cleveland, Hartlepool and Stockton. The MHSOP Service Development Manager has completed a further analysis into the data for these teams; however a patient-level deep dive has not yet been completed. That analysis showed there had been a genuine reduction in treatments in some teams due to the absence of key staff either through vacancies or sickness, but also from the demands attached to the pandemic such as the ability of the team to deliver certain treatments. Across all MHSOP community teams the pandemic has impacted on the delivery of certain treatments (eg group work) and the increased use of remote working is challenging with this patient group; work to promote digital solutions is ongoing. The work also indicated a number of potential issues that may be impacting the data including the mis-recording of treatment codes and the waiting times in the acute sector for diagnostic scans to be completed prior to treatment commencement. However, at this stage it is uncertain the extent of the impact, if any. It is evident further work is required to identify the underlying issues and mitigating actions that can be taken to improve performance in this area.
- Rejected referrals within the LD North Community team are now being recorded correctly but as this measure is reported 3 months behind it will be April before we are able to see if this has had the desired impact.
- The Head of Corporate Performance has discussed the use and recording of assessment codes with clinical leads involved in the development of CITO (as opposed to the original action with Clinical Leaders Board) which is a hub that will integrate with systems such as PARIS, our patient system. CITO follows the patient journey which will make it easier for clinical staff to record relevant information at the right time. It is agreed that this is a better solution to support improvements in this measure going forward. Further work will be undertaken in collaboration with the clinical services to develop what information is required. An update on this will be provided in May.

Actions we said we would take

- MHSOP Community Teams to undertake a patient-level analysis to identify the impact of the service models on performance.
- The incorrect recording of rejected referrals within the LD North Community Teams will be addressed through SDG and an update will be provided to Board in March.
- The Head of Corporate Performance will discuss the use and recording of assessment codes with Clinical Leaders Board in March 21 (date tbc)

Assurance including new actions

- The Service Development Manager MHSOP will complete further work to identify underlying issues and mitigating actions to improve performance. Due to current pressures within the locality, an update will be provided in June.
- The Service, with support from the Corporate Performance Lead, will continue enhanced monitoring of progress during March and April, to ensure rejected referrals within the LD North Community team are being recorded correctly.
- The Head of Corporate Performance will work with the Clinical Leads for CITO to support improvements in this measure going forward. An update will be provided in June.
- Given this issue has been a cause for concern since September 2021, the Corporate Performance Lead will repeat the analysis at service and team level to identify if there are any new issues. An update will be provided in June.

Recommendations

To note the progress made and the actions to be progressed and to receive an update in June 21.

ITEM 16

BOARD OF DIRECTORS

DATE:	**25th March 2021**
TITLE:	**Trust Business Plan update Quarter 3 2020/21**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance and Communications**
REPORT FOR:	**Decision**

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

Executive Summary:

The Trust has continued to attempt to deliver its 20/21 business plan priorities despite the operational challenges of Covid and wider system change. More changes to the plan are required this quarter. Those changes which delete actions or which move them into 21/22 require Board of Directors' approval under current governance arrangements.

Significant changes to the actions within the CYP to AMH transitions Business Plan and Quality Account priority are proposed to take into account new work on 16-25 services. These actions should lead to significant improvements in quality for that age group.

None of the proposed changes runs counter to the new Trust Strategic Direction

Recommendations:

The Board of Directors is recommended to approve all of the proposed changes as set out in Appendix A

MEETING OF:	**Board of Directors**
DATE:	**23rd March 2021**
TITLE:	**Trust Business Plan Quarter 3 2020/21**

1. INTRODUCTION & PURPOSE:

1.1 This report presents the required changes to the current Business Plan, which under current governance arrangements, require Board of Directors' approval.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Current governance arrangements in the Trust allow Senior Leadership Group to make changes to the Business Plan which do not involve a deletion of an action, or the delay of an action to a subsequent financial year. Only Trust Board can currently approve changes that are not within SLG's delegated authority.

3. KEY ISSUES:

3.1 Delivery of the 20/21 Business Plan milestones has again been impeded by Covid. At the end of Q3, **69 of 89 (78%)** actions due for completion had been delivered as currently planned.

3.2 **75%** of overall priorities have no or low risk to the delivery of their final milestones or benefits on time. The 4 priorities / that are predicted to definitely not be concluded on time due to the impact of Covid are Right Care Right Place, Right Staffing, Inpatients Feeling Safe, and Making a Difference Together. The first and last of these will be superseded by the plans being developed to implement the new Strategic Direction. Inpatients Feeling Safe is likely to be superseded by wider priority in the next Quality Account (as discussed at QuAC on 4th March). It is expected that the elements of Right Staffing which must continue will be managed by the workforce subgroup of SLG over the next few months.

3.3 The individual changes to plan which require Board of Directors' approval are listed in Appendix A.. However, Directors should note the significant changes to the actions planned to **improve the clinical effectiveness and patient experience at times of transition from CYP to AMH Services.** This is both a Business Plan and Quality Account priority. Previously planned actions have been superseded by the Trust-wide work on 'Improving Transitions and Service Provision for People aged 16 to 25 years in TEWV." This requires the agreement of the following replacement metrics for the Business Plan and Quality Account:

Action	Metric	Responsibility	Timescale
Identify the issues for CYP to AMH Transitions arising from national policy on the 16-25 age group	Report to Senior Leadership Group meeting	Sarah Smith, CYP Whole Pathway Commissioning Lead	20/21 Q3

Engage children and young people / young adults to develop possible service improvements	Engagement complete	Amanda Wild, Clinical Director Tier 4 CAMHS & CAMHS Provider Collaborative	20/21 Q4
Draft service model completed	Reports to CYP and AMH Service Development Groups	Amanda Wild, Clinical Director Tier 4 CAMHS & CAMHS Provider Collaborative	201/22 Q1
Service Model agreed	Report to Senior Leadership Group and agreement of the recommendations	Amanda Wild, Clinical Director Tier 4 CAMHS & CAMHS Provider Collaborative	21/22 Q2
Implementation of the agreed service model	Actions in the implementation plan delivered within agreed timescales	Amanda Wild, Clinical Director Tier 4 CAMHS & CAMHS Provider Collaborative	To be agreed

4. IMPLICATIONS

4.1 **Compliance with the CQC Fundamental Standards:** The Business Plan and the strategic and operational programmes and projects contain many items which will help us to meet the CQC fundamental standards – e.g. safety, premises and equipment, staffing and person-centred care.

4.2 **Financial/Value for Money:** There are no direct financial implications associated with this paper.

4.3 **Legal and Constitutional (including the NHS Constitution):** The current Trust governance required that deletions of actions, and movement of action completion dates into a subsequent financial year require Board of Directors' approval.

4.4 **Equality and Diversity:** There are no implications arising from this report. .

5. RISKS: There are no risks associated with the recommendations in this report.

6. CONCLUSIONS:

6.1 Although the majority of the business plan actions are being delivered to the currently planned timescales, inevitably there are some actions which have slipped due to the impact of Covid or due to system environmental changes.

6.2 The proposed CYP to AMH Transitions changes to plan reflect the determination of the Trust to consider more deeply the needs of the 16-25 year old cohort and to further improve the quality of service for this group.

7. RECOMMENDATIONS:

7.1 The Board of Directors is recommended to approve all of the proposed changes as set out in Appendix A

Chris Lanigan Head of Planning and Business Development

Appendix A – Requests for Change to Business Plan (including priorities / service developments currently behind or at risk of failure to deliver within time, resource or quality expectations)

Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Due by end	Comment and change request
Implement the NHS Long Term Plan for Mental Health as agreed with each of our commissioners	D&D	AMH	To produce a revised Rehab business case (following review of current options to take place in Q4 19/20)	Rehab Business case submitted to QUAG and LMGB for approval	Q3 20/21	Due to the impact of Covid the service had undertaken 1 of the 2 planned improvement event. 2nd event rescheduled for January 2020. The service manager has updated the timescale to complete the improvement work to confirm the service model. Board are requested to extend timescales to Q2 21/22
	D&D	ALD	Produce a paper to take forward ideas from the Learning Disability Unit (LDU) design event, to further develop provision in D&D	Paper from the LDU design event produced	Q3 20/21	The Trust wide model will be confirmed at the event in April 21. A paper will be developed detailing next steps. New actions will be developed and included in the 21/22 business plan. Therefore Board are requested to remove this action from the 20/21 Business Plan
	D&D	MHSOP	Evaluate new service model	New service model evaluated	Q3 20/21	Due to the impact of Covid the evaluation has not been completed, therefore Board are requested to extend timescale to Q2 21/22
	Forensic	Forensic All	Explore opportunities for development of step down facilities	Identified opportunity progressed	Q3 20/21	Opportunities have been explored but this action has been put on hold due to the development of provider collaborative and agreement of plans with stakeholders. It will be further reviewed as part of the Provider collaborative work Board is requested to remove this action and further actions will be explored in line with the Provider Collaborative Business Plan.
Ensure we deliver the right services in the right place	COO	AMH	Develop plan to implement the new community team structure, in line with outputs from the Kaizen event - to be held in Q4 19/20	Community team implementation plan in place and commenced	Q3 20/21	Model agreed and LCC have signed off the TEWV element in December. Durham County Council management will sign off in January with configuration to be completed by end April 2021. Board is requested to extend timescales to Q1 21/22

Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Due by end	Comment and change request
Ensure we deliver the right services in the right place	COO	D&D AMH	Agree terms of reference for review of street triage and carry out review	Review completed in line with agreed Terms of Reference	Q3 20/21	Due to Covid and operational pressures the review has not commenced. A meeting was held w/c 4 Jan to consider the terms of reference and the priority will be included in the 21/22 Locality Business plan Board are requested to remove from the Trust business plan
Increase the proportion of inpatients who feel safe on our wards	COO	All	Continue monitoring of KPIs during pilot phase of body cameras	Pilot phase KPIs monitored	Q2 20/21	Although the pilot has continued there has been no work on monitoring undertaken due to the Covid-19 Board is requested to extend timescales Q1 21/22
	COO	All	Develop a business case for further roll-out of body cameras (if supported by monitoring of benefit KPIs)	Business case developed	Q3 20/21	There has been a delay due to Covid-19 therefore Board are requested to extend timescales Q2 21/22
Develop and implement a Trust-wide approach to enabling people who have autism to access mental health services	COO	All	Teesside AMH Autism assessment and Diagnosis- Design and delivery of Package to AMH Community Teams (21/22 Q3)	Design Training and Supervision packages implemented in Tees AMH	Q3 21/22	The design & supervision packages have been completed. The roll out to commence April 21, this delay is due to the Covid and operational pressures. Therefore Board are requested to extend timescales to Q1 21/22
	COO	All	Deliver Clinical link pathway for reasonable adjustments in all TEWV CAMHS community teams (20/21 Q4)	Clinical link pathway for reasonable adjustments delivered in all TEWV CAMHS community teams	Q4 20/21	This action is been reviewed as part of the overall programme of work. Meetings with CD and CEO January to map out future actions/details. Therefore Board are requested to remove this action.
Make a Difference Together by ensuring TEWV is an organisation where everyone values each other and feels valued	Chief Executive	All	To Undertake analysis, including use of crowdsourcing data, focus groups with staff and evaluation of wellbeing interventions, to inform future priorities to improve staff wellbeing	Analysis and review completed	Q3 20/21	Progress delayed due to Covid and action to be superseded by work of Great Place to Work SIG. The Big Conversation has identified a number of issues around staff wellbeing which this SIG is considering as it develops proposals for the next business plan. Board are requested to Remove this action

Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Due by end	Comment and change request
Make a Difference Together by ensuring TEWV is an organisation where everyone values each other and feels valued	Chief Executive	All	Develop a work-life balance standard	Standard approved	Q3 20/21	Progress delayed due to Covid and action to be superseded by work of Great Place to Work SIG. Board are requested to Remove this action
	Chief Executive	All	Introduce health and wellbeing impact assessments, and develop plan for use as part of all organisational change initiatives	H&WB impact assessment embedded in the organisational change initiatives	Q3 20/21	Progress delayed due to Covid and action to be superseded by work of Great Place to Work SIG. Board are requested to Remove this action
	Chief Executive	All	Role of workplace health champions to be expanded within localities	Workplace champions allocated in each locality	Q3 20/21	Progress delayed due to Covid and action to be superseded by work of Great Place to Work SIG. Board are requested to Remove this action
Ensure we have the right staffing for our services now and in the future	Nursing and Governance	NA	Gain a better understanding of why staff are leaving the organisation	Obtain feedback from 100% of leavers and provide targeted support and interventions to improve retention	Q4 20/21	There has been some delays due to COVID and capacity within team as they have been 'redeployed' to support clinical services at various times for the period of April 2020 to October 2020. As a result Board are requested to extend the timescales to Q2 21/22

Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Due by end	Comment and change request
Further improve the clinical effectiveness and patient experience at times of transition from CYP to AMH Services	N&G	CYPS AMH	Extend the work of the NHSI Transitions Collaborative project into an internal 3-year project that oversees the development and delivery of key quality improvements	Established Internal Transitions Collaborative – based on the NHS I model, delivered internally	Q3 20/21	This work is superseded by a new Trust-wide project: 'Improving Transitions and Service Provision for People aged 16 to 25 years in TEWV' Therefore Trust Board are requested to remove these actions to ensure there is no duplication or divergence and replace them with the actions, metrics and responsible leader as set out in the table on pages 2 and 3 of this report.
	N&G	CYPS AMH	The here-with called 'Preparing for Adulthood Collaborative' (tbc) will develop an action plan to implement key learning in the 1st year and establish strategies and trajectories for years 2 & 3.	Action plan completed	Q4 20/21	
	N&G	CYPS AMH	Sustain & maintain improvements in the clinical effectiveness and patient experience at times of transition from CAMHS to AMHS.	Collaborative Monitoring documentation – regularly reviewed.	Q4 20/21	
	N&G	CYPS AMH	Report on progress against plans agreed at the Collaborative	Agreed actions being delivered within the deadlines set out in the plan	Q3 20/21	

ITEM NO. 18

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th March 2021**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

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

Report:

The Board is asked to note the following use of the Trust seal in accordance with Standing Order 15.6:

Ref.	Date	Document	Sealing Officers
400	16.03.21	Contract documents relating to the Bacchus House scheme	Brent Kilmurray, Chief Executive Phil Bellas, Trust Secretary

Recommendations:

The Board is asked to receive and note this report.